

PLANNING COMMISSION AGENDA Thursday, January 21, 2016

Notice is Hereby Given that the Herriman Planning Commission shall assemble for a

meeting in the City Council Chambers, located at 13011 South Pioneer Street (6000 West), Herriman, Utah.

6:00 PM - Work Meeting: (Front Conference Room)

Closed Session:

Closed session for the Planning Commission to act in a quasi-judicial capacity to act on a reasonable accommodation filed by Michael Demie and Renew Wellness and Recovery with respect to property located at 13727 S Rocky Point Drive pursuant to the authority identified by the Utah Supreme Court in *Dairy Product Services, Inc. v. City of Wellsville*, 13 P.3d 581, 595 (Utah 2000).

Review of Agenda Items

7:00 PM - Regular Planning Commission Meeting:

1. General Business:

Welcome

- 1.1 Invocation and Pledge
- 1.2 Roll call
- 1.3 Approval of Minutes for: **January 7, 2016**

2. Administrative Items:

Administrative items are reviewed based on standards outlined in the ordinance. Public comment is taken on relevant and credible evidence regarding the applications compliance with the ordinance.

- 2.1 **20S14** RDM Land & Development 6769 W 14600 S Proposed Approval of the CCR's for The Ridge Subdivision (Continued from December 17, 2015)
- 2.2 **38S15** Edge Homes 13295 S Herriman Rose Blvd Proposed Subdivision of Single Family Cluster Units and Condos Zone: MU-2 Acres: 11.64 Units: 148 (Continued from January 7, 2016)
- 2.3 **14C08-19** Edge Homes 13295 S Herriman Rose Blvd Final Master Plan Approval of Single Family Cluster Units and Condos Zone: MU-2 Acres: 11.64 Units: 148 (Continued from January 7, 2016)
- 2.4 **01C16** Nielsen 13677 S 6315 W Proposed Conditional Use for a Secondary Unit Zone: A-.50 Acres: .56

- 2.5 **O1S16** Rosecrest Communities, LLC 14868 S Juniper Crest Rd Proposed Subdivision of Single Family Dwellings Zone: R-1-15 Acres: 14.25 Units: 30 (PUBLIC HEARING)
- 2.6 O1C99-15 Rosecrest Communities, LLC 14868 S Juniper Crest Rd Final PUD Approval for 30 Single Family Lots Zone: R-1-15 Acres: 14.25 Units: 30
- 2.7 **O2S16** Clayton Homes, Inc 5500 W 12100 S Proposed Subdivision of Townhomes Zone: R-2-10 Acres: 8.91 Units: 100 (PUBLIC HEARING)
- 2.8 **38C14-03** Clayton Homes, Inc 5500 W 12100 S Final PUD Approval for 100 Townhomes Zone: R-2-10 Acres: 8.91 Units: 100
- 2.9 **O1P16** Demie 13727 S Rocky Point Dr Request for a Reasonable Accommodation for up to 12 Occupants for a Residential Recovery Facility Zone: A-1

3. New Items of Subsequent Consideration:

4. Future Meetings:

- Joint Planning Commission/City Council Work Meeting Wednesday, January 27, 2016 @ 6:00 PM
- 4.2 Planning Commission Meeting Thursday, February 4, 2016 @ 7:00 PM
- 4.3 City Council Meeting Wednesday, February 10, 2016 @ 7:00 PM

5. ADJOURNMENT:

- In accordance with the Americans with Disabilities Act, Herriman City will make reasonable accommodation for participation in the meeting. Request assistance by contacting Herriman City at (801) 446-5323 and provide at least 48 hours advance notice of the meeting.
- LECTRONIC PARTICIPATION: Members of the planning commission may participate electronically via telephone, Skype, or other electronic means during this meeting.
- ♣ PUBLIC COMMENT POLICY AND PROCEDURE: The purpose of public comment is to allow citizens to address items on the agenda. Citizens requesting to address the commission will be asked to complete a written comment form and present it to Cindy Quick, Deputy Recorder. In general, the chair will allow an individual three minutes to address the commission. A spokesperson, recognized as representing a group in attendance, may be allowed up to five minutes. This policy also applies to all public hearings.

l, Cindy Quick, certify the foregoing Herriman City Planning Commission agenda was emailed to at least one newspaper of general circulation within the geographic jurisdiction of the public body. The agenda was also posted at the principal office of the public body, at the building where the meeting is to be held. It was also posted on the Utah State Website http://www.utah.gov/pmn/index.html and on Herriman City's website www.herriman.org.

Dated and Posted this 14th day of January, 2016

Cindy Quick, CMC Deputy Recorder



HERRIMAN CITY PLANNING COMMISSION MEETING MINUTES

Thursday, January 7, 2016 Waiting Formal Approval

6:01:15 PM 6:00 P.M. ~ Work Meeting (Open to the Public)

Attendance

Planning Commission Members:

Chris Berbert
Blayde Hamilton
Adam Jacobson
Jessica Morton
Robyn Shakespear
Clint Smith

Wade Thompson

Council Members:

Mayor Freeman, Coralee Wessman-Moser

City Staff:

Bryn McCarty, City Planner
Sandra Llewellyn, Planner I
Heather Upshaw, Senior Planner
Gordon Haight, Assistant City Manager
Ionathan Rowers, Engineering

Jonathan Bowers, Engineering John Brems, City Attorney

The preparation of planning packets was briefly discussed. A discussion about home occupations with outside uses took place. Currently a business would not be allowed to have outside services such as swimming lessons or horseback riding. Requirements for daycares were also discussed. A suggestion of listing specific uses for home occupations was suggested.

♣ <u>6:08:20 PM</u> Heseltine – Cocomo St

It was explained to the commission that the owner wants to put two homes on a one acre site. There is an existing home there. The property would be subdivided in half and a home would be built on the back property. City Planner, Bryn McCarty reminded the commission that the property is on a private street that is not paved. Commission noted that they would not go against current ordinance and suggested an option of dedicating the street to the city to get it paved.

6:11:34 PM Review of Agenda Items

2.1 KW Advisory Group. It was noted that there are 32 lots for the proposal and the plan had been modified to incorporate the roundabout. Density calculations were discussed and it was noted that a density bonus could be given for infrastructure of the roundabout.

2.2 & 2.3 Edge Homes. The stub road was removed as requested, the power corridor was included to provide more of a buffer along the lots on the east end of the development and the detention pond was moved. Concerns noted were for the request for a 10 foot rear yard setback and the size of the lots on the east end of the development. There will be a trail along the power corridor.

2.4 & 2.5 Tim Soffe. The applicant was asking for final approval of the first two phases and the third phase will come back for final approval. A parking study was completed. Alley ways are 26 feet wide. Elevations and color boards will be presented when they come back.

2.6 JEDSCO LLC. The applicant was requesting an extension due to the market and the other developments around them. Possible benefits of allowing an extension were discussed.

2.7 & 2.5 Edge Homes. The Shadow Run development will have a trail that connects to the canyon. There will be a club house and a tot lot.

2.9 & 2.10 Edge Homes. The proposed condos would be next to UTA Trax. The applicant took time to detail the parking along private drives and parking stalls in the development. Concerns were voiced regarding the width of the alley ways and safety of residents when backing out of the garage and driveway.

2.11 Herriman City. Proposed Pump Station.

3.1 Text Change for Family Food Production. Request to exclude roosters and add one medium animal.

Meeting adjourned at 7:01:42 PM

7:07:38 PM 7:00 P.M. ~ Regular Planning Commission Meeting

Attendance

Planning Commission Members:

Chris Berbert
Blayde Hamilton
Adam Jacobson
Jessica Morton
Robyn Shakespear
Clint Smith

Clint Smith Wade Thompson

Council Members:

Mayor Freeman, Coralee Wessman-Moser

City Staff:

Bryn McCarty, City Planner Sandra Llewellyn, Planner I Heather Upshaw, Senior Planner Cindy Quick; Deputy Recorder Jonathan Bowers, Engineering John Brems, City Attorney

1. **GENERAL BUSINESS:**

Chair Clint Smith welcomed those in attendance.

1.1 7:08:04 PM Reverence / Thought: Donald Speth

- 1.2 7:08:50 PM Pledge of Allegiance: Paul Mendenhall
- 1.3 7:09:30 PM Roll call: Full Quorum, Jeramy Burkinshaw absent
- 1.4 <u>7:09:38 PM</u> Approval of Minutes for: **December 17, 2015**

Commissioner Chris Berbert **MOVED** to approve the minutes for December 17, 2015.

Commissioner Adam Jacobson SECONDED the motion.

The voting was unanimous.

Vote passed.

Motion carried.

Chair Clint Smith reviewed the public comment policy and procedure.

2. Administrative Items:

Administrative items are reviewed based on standards outlined in the ordinance. Public comment is taken on relevant and credible evidence regarding the applications compliance with the ordinance.

2.1 <u>7:12:36 PM</u> **26S15** – KW Advisory Group – 7360 W 13300 S – Proposed Single Family Lot Subdivision – Zone: A-.25 – Acres: 13.75 – Units: 31 (PUBLIC HEARING opened November 5, 2015)

City Planner, Bryn McCarty oriented the commission with an aerial map, site plan and other images prepared. The item was continued from November 5th to work the roundabout into the plan. It was noted that there are 32 lots and density points need to be reviewed.

Colby Bond, KW Advisory Group, 1514 W 925 S, Syracuse, explained that they consider the roundabout to be a system improvement which would give an additional .2 in density.

Commissioner Chris Berbert wondered why a visual barrier was not required on the south side of the development. The response was that fencing is mostly required next to adjacent properties. Commissioner Berbert noted the possibility of several different fence types along a main road because the lots along that road are backyards. He felt a continuous fence along that main road would be more appropriate. Commissioner Blayde Hamilton agreed and suggested a masonry fence and a landscaping as well.

7:17:52 PM Chair Smith called for any citizen who would like to speak on this item to come to the podium, fill out a comment form and state their name and address for the record.

Citizen Comments:

None

7:18:25 PM Chair Smith closed the public hearing.

The Planning Commission suggested that the landscaping come back for approval and would like to require fencing along the main road.

Commissioner Adam Jacobson **MOVED** to approve the item with a clarification that states the units of 32 (because it was not shown on the agenda) with the following changes to staff recommendations: number nine, to provide an additional 10 foot landscaping right-of-way along 13100 South (by the developer); amendment 10, the subdivision allowed a maximum of 2.35 units per acre based on the density criteria,

therefore only 32 lots are approved, with the requirement that only 30 lots are built according to fire, until the second access is brought in; with an additional requirement, item 11, which requires a south masonry fence that parallels Canyon Road along the south side of all of the lots from lot 111 to lot 132; item 12, a landscape plan to come back to planning commission for approval to address all of the 10 foot additional landscaping, as well as, the roundabout.

Commissioner Chris Berbert SECONDED the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton Yes
Commissioner Blayde Hamilton Yes
Commissioner Robyn Shakespear Yes
Commissioner Chris Berbert Yes
Commissioner Adam Jacobson Yes
Commissioner Wade Thompson Yes

Vote passed.

Motion carried.

2.2 <u>7:23:52 PM</u> **32S15** – Edge Homes – 6400 W Herriman Parkway – Proposed Single Family Subdivision – Zone: R-2-10 – Acres: 38.23 – Units: 104 (PUBLIC HEARING held on December 3, 2015)

Chair Clint Smith noted that item 2.2 will be discussed with item 2.3. No additional comments will be taken but additional comments were received and will be part of the record. (See attached)

City Planner, Bryn McCarty explained that this item was continued to remove a stub road and to slide another road over to give separation between the two entrance points. Setbacks and lots sizes on the east side of the development were of concern.

Brandon Watson, Edge Homes, 482 W 800 N, Orem, reiterated the changes made to the plan as mentioned and stated that he could waive the setback request for the lots on the east side of the development. However, he asked that the lot sizes remain unchanged.

Chair Clint Smith asked what the plan would be for the lots on the east side if the setback request was waived. Mr. Watson felt that the home sizes would need to be smaller and felt that the power corridor and the road was a sufficient buffer from the adjacent neighborhood. It was noted that the power corridor will be landscaped and would include a trail which would be an amenity to the city.

City Planner, Bryn McCarty asked for clarification about the swell on the south side and whether or not it was needed. The applicant noted he would waive the request if it is not needed/desired. Planning Commission would like to see the detention area utilized.

Commissioner Adam Jacobson MOVED to approve the item with staff recommendations.

Commissioner Blayde Hamilton **SECONDED** the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton

Commissioner Blayde Hamilton

Commissioner Robyn Shakespear

Commissioner Chris Berbert

Commissioner Adam Jacobson

Commissioner Wade Thompson

Yes

2.3 7:34:19 PM 42C15 - Edge Homes - 6400 W Herriman Parkway - Final PUD Approval Zone: R-2-10 - Acres: 38.23 - Units: 104 (Continued from December 17, 2015)

Commissioner Adam Jacobson **MOVED** to approve the item with alteration of number four, to strike out, 'and only require that all rear yards are 15 feet.'

Commissioner Jessica Morton SECONDED the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton

Commissioner Blayde Hamilton

Commissioner Robyn Shakespear

Commissioner Chris Berbert

Commissioner Adam Jacobson

Commissioner Wade Thompson

Yes

Vote passed.

Motion carried.

2.4 <u>7:35:20 PM</u> **36S15** – Tim Soffe – 14199 S 4800 w – Proposed Subdivision of Townhomes, Courtyard Units, Stacked Flats and Commercial – Zone: MU-2 – Acres: 37.32 – Units: 501 (PUBLIC HEARING held on December 17, 2015)

Chair Clint Smith noted that item 2.4 and item 2.5 will be discussed together.

City Planner, Bryn McCarty oriented the commission with a site plan, and outlined changes made to the plan. Applicant is looking for final approval for the first two phases and the third phase will come back with construction timing and elevations. Elevation images for the development were shown. Preliminary approval would include approval for density.

Tim Soffe, 5151 S 900 E, explained that the condition for 4000 West and the right-of-way will be addressed with the final phase. Parking analysis was done and it was discovered that there was an excess in parking. There will be no parking allowed on public streets. There will be parking allowed on private streets. The color/materials board will be submitted when they come back.

Commission noted that 4000 West could be dealt with on the final phase along with the color/materials board. Commissioner Adam Jacobson requested that the parking be contingent upon the final phase.

Commissioner Adam Jacobson **MOVED** to approve the item with staff recommendations.

Commissioner Wade Thompson **SECONDED** the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton

Commissioner Blayde Hamilton

Commissioner Robyn Shakespear

Commissioner Chris Berbert

Commissioner Adam Jacobson

Yes

Commissioner Wade Thompson

Yes

2.5 <u>7:43:26 PM</u> **45C15** – Tim Soffe – 14199 S 4800 w – Final Master Plan Approval of Townhomes, Courtyard Units, Stacked Flats and Commercial – Zone: MU-2 – Acres: 37.32 Units: 501 (Continued from December 17, 2015)

Commissioner Adam Jacobson MOVED to approve the item with staff recommendations and two adjustments; item nine, that all of the material boards come back to planning commission for approval on phases one and two and that phase three will still come back for final approval; item ten, that the parking is approved as submitted – for phase one and two; that a total of 729 parking spaces are approved, including driveways and garages; with the mixed use parking that the total of the surface spaces cannot be reduced below 315 and that the flats and loft structure of parking spaces is 199 and retail 136.

Commissioner Chris Berbert **SECONDED** the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton

Commissioner Blayde Hamilton

Commissioner Robyn Shakespear

Commissioner Chris Berbert

Commissioner Adam Jacobson

Commissioner Wade Thompson

Yes

Vote passed. Motion carried.

2.6 <u>7:45:58 PM</u> **09S14/23C14** – JEDSCO LLC – 7300 W Rose Canyon Rd – Proposal for a 2 Year Extension of Subdivision and PUD Approval – Zone: A-.25 – Acres: 32 – Units: 61

City Planner, Bryn McCarty oriented the commission with a layout. The applicant would like to get a two year extension to allow for time to get the lots sold.

Paul Mendenhall, 149 W 1650 N, Centerville, reported working on a number of opportunities with sales and development. The property was approved in 2014 with plans approved in 2015. Since then, 7300 West has changed and competition is heavy. The applicant would like to wait to let the market conditions improve. The applicant committed to doing the site work at one time once it gets started.

City Planner, Bryn McCarty noted that engineering approvals do expire after two years and the applicant will need to go through the process again. Applicant stated that they understood that requirement.

Commissioner Blayde Hamilton **MOVED** to approve the item with the same staff requirements as originally approved.

Commissioner Wade Thompson **SECONDED** the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton

Commissioner Blayde Hamilton

Commissioner Robyn Shakespear

Commissioner Chris Berbert

Commissioner Adam Jacobson

Commissioner Wade Thompson

Yes

2.7 <u>7:52:19 PM</u> **39S15** – Edge Homes – 14508 S Autumn Crest Blvd – Proposed Subdivision of Townhomes – Zone: MU-2 – Acres: 17.8 – Units: 218 (PUBLIC HEARING)

Chair Clint Smith noted that item 2.7 will be discussed with item 2.8.

City Planner, Bryn McCarty oriented the commission with a site plan and layout along with images of the elevations for the project.

Jaran Nicholls (applicant), Edge Homes, 482 W 800 N, Orem, reported how fun the project has been for them and how pleased they are with how it has turned out. The proposal is for the second phase. The topography of the area has allowed for some pretty views. He noted that the southern border is next to Juniper Canyon and reported where a tot lot will be located. Images were shown to indicate that a similar structure would be included in the development. The development will have a model home and three styles of townhomes. The color schemes and materials used will be the same as the previous phase of Shadow Run. Each town home style was shown and described.

8:00:10 PM Chair Smith opened the public hearing and called for any citizen who would like to speak on this item to come to the podium, fill out a comment form and state their name and address for the record.

Citizen Comments:

Breanna Barney, 4433 W Hill Shadow Way, lives in the first phase of shadow run phase, she was told that no town homes would be built behind her. However, the proposed plan shows four units directly behind her. She noted that neighbors were told the same thing. She has concern with the placement of the tot lots as well.

8:02:25 PM Chair Smith closed the public hearing.

Steve Maddox (applicant), requested to address concerns with Ms. Barney after the meeting.

Commissioner Chris Berbert requested that the size of the tot lot be defined. The applicant responded that the size will be 30' x 50'.

Commissioner Chris Berbert MOVED to approve the item with all staff recommendations and requirements.

Commissioner Jessica Morton SECONDED the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton Yes
Commissioner Blayde Hamilton Yes
Commissioner Robyn Shakespear Yes
Commissioner Chris Berbert Yes
Commissioner Adam Jacobson Yes
Commissioner Wade Thompson Yes

Vote passed.

Motion carried.

2.8 <u>8:07:31 PM</u> **56Co7-11** – Edge Homes – 14508 S Autumn Crest Blvd – Proposed Final PUD Approval of Townhomes – Zone: MU-2 – Acres: 17.8 – Units: 218

Commissioner Chris Berbert **MOVED** to approve the item with PUD requirements with adding in number 12, that there be a $30' \times 50'$ tot lot size with appropriate structure to fill it.

Commissioner Robyn Shakespear **SECONDED** the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton Yes
Commissioner Blayde Hamilton Yes
Commissioner Robyn Shakespear Yes
Commissioner Chris Berbert Yes
Commissioner Adam Jacobson Yes
Commissioner Wade Thompson Yes

Vote passed.

Motion carried.

2.9 <u>8:08:34 PM</u> **38S15** – Edge Homes – 13295 S Herriman Rose Blvd – Proposed Subdivision of Single Family Cluster Units and Condos – Zone: MU-2 – Acres: 11.64 – Units: 148 (PUBLIC HEARING)

Chair Clint Smith noted that item 2.9 and item 2.10 will be discussed together.

City Planner, Bryn McCarty oriented the commission with a site plan. The project will be adjacent to the phase previously approved and will be next to the UTA Trax line and the Salt Lake Community College. Images for the elevations were shown.

Steve Maddox (applicant), Edge Homes, 480 W 800 N, Orem, it was noted that there would be a walking trail from the Salt Lake Community College to the open space and proposed a sport court that would allow full court soccer and would be open to the community. The development will accentuate the area with the tower property to the east. Private road ways allow accessibility between communities and neighborhoods. The available parking was outlined. There will be no parking on public streets and there will be more parking stalls than required. The HOA will landscape the community and maintain the landscaping. Property line will be defined with a two rail fence until UDOT comes in and puts in their fence. The 10-plex units are for sale and all single family homes have basements.

8:16:57 PM Chair Smith opened the public hearing and called for any citizen who would like to speak on this item to come to the podium, fill out a comment form and state their name and address for the record.

Citizen Comments:

None

<u>8:17:24 PM</u> Chair Smith closed the public hearing.

Planning Commission discussion items included the sports court requirement, concern with alley width and parking issues by the 10-plex, concern with the 20 foot width of the alley loaded product. Assistant City Engineer, Jonathan Bowers noted that preference would be for a 24 foot width, driveable surface. The 20 foot mentioned in the ordinance is not standard. Commissioner Blayde Hamilton reminded the commission that the development is next to the corridor. Commissioner Adam Jacobson suggested that the applicant provide striping and signage stating visitor parking only along the 10-plex units. Applicant accepted the request. Commissioner Jacobson requested that a requirement that UTA ROW be noted on the plat.

Commissioner Adam Jacobson **MOVED** to approve the item with an eighth requirement that the UTA right-of-way is denoted on the plat.

City Planner, Bryn McCarty announced that the parking may not be right and should still be looked at because the plan was presented to staff right before the meeting.

Commissioner Adam Jacobson revised his motion.

Commissioner Adam Jacobson MOVED to continue the item without date.

Commissioner Blayde Hamilton **SECONDED** the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton

Commissioner Blayde Hamilton

Commissioner Robyn Shakespear

Commissioner Chris Berbert

Commissioner Adam Jacobson

Yes

Commissioner Wade Thompson

Yes

Vote passed. Motion carried.

2.10 <u>8:36:50 PM</u> 14Co8-19 – Edge Homes – 13295 S Herriman Rose Blvd – Final Master Plan Approval of Single Family Cluster Units and Condos – Zone: MU-2 – Acres: 11.64 – Units: 148

Commissioner Adam Jacobson MOVED to continue the item without date.

Commissioner Wade Thompson **SECONDED** the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton Yes
Commissioner Blayde Hamilton Yes
Commissioner Robyn Shakespear Yes
Commissioner Chris Berbert Yes
Commissioner Adam Jacobson Yes
Commissioner Wade Thompson Yes

Vote passed.

Motion carried.

2.11 <u>8:37:27 PM</u> **51C15** – Herriman City – 15102 S 3200 W – Proposed Culinary Water Pump Station Zone: A-1 – Acres: 4.77

City Planner, Bryn McCarty oriented the commission with an aerial map, site plan and other images prepared. It was noted that the fencing will be around the perimeter of the pump station site not the entire property.

Commissioners felt that fencing should be the same as required for other utility buildings to keep consistent.

Commissioner Adam Jacobson **MOVED** to approve the item with staff recommendations with an adjustment to item three, to install a six foot masonry wall around the entire property, meaning the triangle and detention pond area, not the land next to it.

Commissioner Blayde Hamilton **SECONDED** the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton Yes
Commissioner Blayde Hamilton Yes
Commissioner Robyn Shakespear Yes
Commissioner Chris Berbert Yes

Commissioner Adam Jacobson Yes
Commissioner Wade Thompson Yes

Vote passed.

Motion carried.

3. <u>Legislative Items:</u>

Legislative items are recommendations to the City Council. Broad public input will be taken and considered on each item. All legislative items recommended at this meeting will be scheduled for a decision at the next available City Council meeting.

3.1 <u>8:46:10 PM</u> **27Z15** – Herriman City – Proposed Text Change to the Land Use Ordinance Regarding Family Food Production (PUBLIC HEARING)

City Planner, Bryn McCarty oriented the commission with a text change to family food production. Changes would exclude roosters and add one medium sized animal. Staff received emails suggesting that perhaps it should be two animals. This would be a recommendation to the council.

8:48:07 PM Chair Smith opened the public hearing and called for any citizen who would like to speak on this item to come to the podium, fill out a comment form and state their name and address for the record.

Citizen Comments:

George Allen, 14966 S Castle Valley Drive, offered comments concerning the pumphouse.

Chair Smith reminded Mr. Allen that the item on for public hearing was for the text change to family food production not the pumphouse. He asked Mr. Allen to work with staff regarding his concerns with the pumphouse.

8:50:40 PM Chair Smith closed the public hearing.

City Planner, Bryn McCarty reminded commission about emails received stating concerns of adding two medium animals instead of just one. Chair Clint Smith pointed out the possibility that the text change could allow for 2 goats or 2 sheep on a very small lot because the proposal would be for .49 acres or less. He mentioned there being great value in 4H programs and he supports them, however, an A zone can have very small lot sizes and it may be of concern. Commissioner Adam Jacobson reported being fine with allowing roosters in a family food production zone and thought roosters should not be excuded and voiced being fine with adding two medium animals.

Commissioner Adam Jacobson **MOVED** to recommend to city council to approve the ordinance and strike out excluding roosters and add two medium animals for .49 acres or less.

Commissioner Robyn Shakespear **SECONDED** the motion.

Chair Smith asked for a vote. The vote was as follows:

Commissioner Jessica Morton Yes
Commissioner Blayde Hamilton No
Commissioner Robyn Shakespear Yes
Commissioner Chris Berbert Yes
Commissioner Adam Jacobson Yes
Commissioner Wade Thompson Yes

4. New Items of Subsequent Consideration:

None

5. Future Meetings:

- 5.1 City Council Meeting Wednesday, January 13, 2016 @ 7:00 PM
- 5.2 Planning Commission Meeting Thursday, January 21, 2016 @ 7:00 PM

6. **ADJOURNMENT:**

Chair Clint Smith called for a motion to adjourn.

Commissioner Jessica Morton MOVED to adjourn the meeting and Commissioner Adam Jacobson SECONDED the motion. The voting was unanimous. Motion carried.

The meeting adjourned at 8:59:53 PM.

I, Cindy Quick, Deputy Recorder of Herriman City hereby certify that the foregoing minutes represent a true, accurate and complete record of the meeting held on January 7, 2016. This document constitutes the official minutes for the Herriman City Planning Commission Meeting.

Cindy Quick, CMC Deputy Recorder



Date of Meeting: 01/21/16		
File #	20S14	
Applicant	RDM Land & Development	
Address	6769 W 14600 S	
Request	Proposed Approval of the CCR's for The Ridge Subdivision	

DECLARATION OF COVENANTS, CONDITIONS AND RESTRICTIONS

FOR

THE RIDGE AT HERRIMAN PHASE I & II

a Residential Community in the City of Herriman, State of Utah

DECLARATION OF COVENANTS, CONDITIONS AND RESTRICTIONS FOR THE RIDGE AT HERRIMAN Phase I & II

THIS DECLARATION OF COVENANTS, CON	NDITIONS AND RESTRICTIONS FOR THE RIDGE AT
HERRIMAN ("Declaration") is made this	day of October, 2015, by Herriman Ridge Properties, a
Utah limited liability company (the "Declarant").	

Recitals:

- A. Declarant is the Owner of certain real property located in Salt Lake County, Utah (the "Property"), more particularly described in Exhibit A to this Declaration. Declarant has recorded, or will record, a subdivision plat against the Property with the Salt Lake County Recorder's Office, which plat creates the residential lots depicted on the plat. This Declaration is being imposed on the Property, and is intended to create binding servitudes that run with the land of the Property.
- B. Declarant intends to develop a residential subdivision on the Property and convey all of the lots therein subject to a general plan of development and to the covenants, conditions and restrictions set forth in this Declaration.

Declaration:

NOW THEREFORE, Declarant declares as follows:

All lots within the Property shall be held, sold, conveyed, encumbered, leased, used, occupied and improved subject to the protective covenants, conditions, restrictions and equitable servitudes set forth in this Declaration. It is the intention of the Declarant in imposing these covenants, conditions and restrictions to create a general plan of development, and to protect and enhance the property values and aesthetic values of the Property. The covenants, conditions and restrictions contained herein are intended to and shall run with the title of the land, and be binding upon the successors, assigns, heirs, and any other persons holding any ownership or possessory interest in the Property, and shall inure to the benefit of all other lots in the Property and the Association.

The covenants, conditions and restrictions shall be binding upon the Declarant and its successors in interest, and may be enforced by the Declarant, the Association, or by any Owner, as hereinafter defined. Notwithstanding the foregoing, no provision of this Declaration shall prevent the Declarant from doing any of the following, which shall be deemed to be among Declarant's reserved rights in addition to such rights as may be described elsewhere in this Declaration: (1) Installation and completion of Improvements, as hereinafter defined; (2) Use of any Lot owned by the Declarant as a model home, or for the placement of a temporary construction or sales office; (3) Installation and maintenance of signs incidental to sales or construction, subject to applicable laws and ordinances; and (4) Assignment of Declarant's rights under this Declaration in whole or part to one or more builders intending to construct homes on the Property.

Notwithstanding any applicable theory relating to a mortgage, deed of trust or similar instrument, the term Lot Owner, Owner, or Owners shall not mean or include the mortgagee or beneficiary or trustee under a deed of trust unless and until such party has acquired title pursuant to foreclosure or any arrangement or

proceeding in lieu thereof.

ARTICLE I DEFINITIONS

Unless the context clearly requires otherwise, the following terms used in this Declaration shall have the following meanings:

"City" shall mean the city of Herriman, Utah, and its appropriate departments, officials and boards.

"Committee" shall mean the architectural review committee created under Article VI of this Declaration.

"Property" shall have the meaning set forth in the recitals.

"Declarant" shall mean Green Haven Investors, a Utah limited liability company, and its successors and assigns.

"<u>Declaration</u>" shall mean this Declaration of Covenants, Conditions and Restrictions, together with any subsequent amendments or additions.

"Dwelling" shall mean the single family residence built or to be built on any Lot, including the attached garage.

"<u>First Mortgage</u>" shall mean and refer to any unpaid and outstanding mortgage, deed of trust or other security instrument encumbering a Lot recorded in the records of the Salt Lake County Recorder's Office, having priority of record over all other recorded liens except those governmental liens made superior by statute.

"<u>First Mortgagee</u>" shall mean and refer to any person named as a mortgagee or beneficiary under any First Mortgage, or any successor to the interest of any such person under such First Mortgage.

"Improvement" shall mean all structures and appurtenances of every type and kind, including but not limited to buildings, dwellings, garages, parking enclosures, storage buildings, walkways, retaining walls, sprinklers, pipes, driveways, fences, walls, curbs, landscaping, gazebos, basketball courts, tennis courts, pools, outdoor hot tubs or spas, decks, stairs, poles, lighting, signs, trampolines, satellite dishes or other antennas, any mechanical equipment located on the exterior of a building, and any hard surfaced area in excess of 100 square feet.

"Lot" shall mean any numbered building Lot shown on any official plat of all or a portion of the Property.

"Owner" shall mean the person or persons having title to any Lot. Owner shall mean the person holding fee simple title, including the Declarant, and buyers under any contract for deed, but shall exclude any person or entity holding title for purposes of securing performance of an obligation, including the trustee and/or beneficiary under a deed of trust or mortgagee under a mortgage.

"Paths" shall mean the paths established for walking and bicycle travel which are shown on the Plat.

"Plat" shall mean an official subdivision plat of any portion of the Property, as approved by the City and recorded in the office of the Salt Lake County Recorder, as such plat may be amended from time to time.

"Storm Water Permit" shall mean the UPDES Storm Water General Permit For Construction Activities which the buyer or Owner of each Lot shall be required to obtain from the Division of Water Quality of the Utah Department of Environmental Quality, as set forth in Section 10.5 below.

"Subdivision Improvements" shall mean all improvements and facilities to be installed outside of the boundaries of Lots or within easements for Paths, as identified on the Plat, including those items that are necessary to provide access and utility service to the Lots and items required by the City as a condition of its approval of subdivision of the Property.

ARTICLE II RESTRICTIONS ON ALL LOTS

- 2.1 Zoning Regulations. The zoning ordinances of the City and any applicable building, fire, and health codes are in full force and effect in the Property, and no Lot may be occupied or used in a manner that is in violation of any such ordinances or codes.
- 2.2 <u>Business or Commercial Uses.</u> No portion of the Property may be used for any commercial, mining, or business use. Nothing in this provision is intended to prevent (a) the Declarant from using one or more Lots for purposes of a construction office or sales office during construction of the Subdivision Improvements or until the Lots are sold, whichever occurs later, or (b) the conduct of a home occupation entirely within a Dwelling. All home occupations must meet the requirements of the Herriman City ordinance.
- 2.3 Restriction on Signs. No signs will be permitted on any Lot within the Property, except for (a) traffic control signs placed by the City, temporary signs warning of some immediate danger, (b) signs not in excess of six square feet identifying the contractor and/or architect of any Dwelling unit while it is under construction, (c) signs indicating the Lot is for sale, which sign must be placed in accordance with City sign regulations and shall not exceed nine (9) square feet in size, and (d) signs stating the address or the name of the owner of a Lot, subject to the consent of the Committee. Notwithstanding the foregoing, the Declarant may erect and maintain a sign at the entrance to the Property for a period of no more that five years after the recordation of the Plat, announcing the availability of Lots and giving sales information. Any additional signage must be approved by the declarant.
- 2.4 <u>Completion Required Before Occupancy.</u> No Dwelling may be occupied prior to its completion and the issuance of a certificate of occupancy by the City.
- 2.5 <u>Dwelling to be Constructed First.</u> No garage, storage unit, or other out-building may be constructed prior to the construction of the Dwelling on a Lot.
- 2.6 <u>Livestock, Poultry and Pets.</u> Must conform with Herriman City zoning ordinances.
- 2.7 <u>Underground Utilities.</u> All gas, electrical, telephone, television, and any other utility lines in the Property are to be underground, including lines within any Lot which service Improvements within that Lot. No propane tanks or oil tanks may be installed on any Lot except for temporary heat during construction.
- 2.8 <u>Service Yards.</u> No clothes lines, service yards, or storage yards shall be permitted. Exterior mechanical equipment must be screened in a manner approved by the Committee so that it is not visible from adjoining Lots, except as provided herein.

- 2.9 Maintenance of Property; Cleanliness. All Lots and the Improvements and landscaping on them shall be maintained in a clean, sanitary, and attractive condition at all times. No unsightliness is permitted on any Lot. This shall include, without limitation, the open storage of any building materials (except during construction of Improvements) open storage or parking of farm or construction equipment, boats, campers, camper shells, trailers, trucks larger than pick-up trucks (except during periods of actual loading and unloading) or inoperable motor vehicles; accumulations of lawn or tree clippings or trimmings; accumulations of construction debris or waste; household refuse or garbage except as stored in tight containers in an enclosure such as a garage; lawn or garden furniture except during the season of use; and the storage or accumulation of any other material, vehicle, or equipment on the Lot in a manner that is visible from any other Lot or any public street. Notwithstanding the preceding sentence, Owners may store boats, trailers, recreational vehicles and similar items on their Lots so long as such items are located behind a fence or are otherwise screened from view such that they are not visible from the street in front of the Lot. Each Lot Owner shall be responsible to maintain his or her Lot and all Improvements and landscaping on the Lot in an attractive manner so as to not detract from the appearance and ambiance of the subdivision. Vacant Lots shall be clean in appearance and shall be kept free from refuse, debris, unsightly weeds, and potential fire hazards.
- 2.10 <u>No Noxious or Offensive Activity.</u> No noxious or offensive activity shall be carried out on any Lot, including the creation of loud or offensive noises or odors that detract from the reasonable enjoyment of nearby Lots.
- 2.11 No Hazardous Activity. No activity may be conducted on any Lot that is, or would be considered by a reasonable person to be unreasonably dangerous or hazardous, which would cause the cancellation of conventional homeowner's insurance policy. This includes, without limitation, the storage of caustic, toxic, flammable, explosive or hazardous materials in excess or those reasonable and customary for household uses, the discharge of firearms or fireworks other than in connection with celebration of the 4th of July and 24th of July, 31st December holidays, as permitted by local jurisdiction, and setting open fires (other than properly supervised and contained barbecues).
- 2.12 <u>Exterior Lighting</u>. Any outdoor lighting shall be subject to approval by the Committee, and no outdoor lighting shall be permitted except for lighting that is designed to aim downward and limit the field of light to the confines of the Lot on which it is installed. This restriction shall not prevent street lighting maintained by the City a front yard post light.
- 2.13 Annoying Sounds. No speakers, wind-bells, wind chimes, or other noise making devices may be used or maintained on any Lot which creates noise that might reasonably be expected to be unreasonably or annoyingly loud to adjoining Lots, except for security or fire alarms.
- 2.14 <u>Fuel Storage</u>. No fuel, oil, gasoline, propane, or other fuel storage tanks may be installed or maintained on the property. Dwellings shall be heated with natural gas, solar, or electric heat. Propane or other such containerized fuels may be used only during construction of the Dwelling until the permanent heating system is installed and operational. This does not include any outdoor cooking such as barbeques.
- 2.15 <u>Transient Lodging Prohibited</u>. Lots are to be used for residential housing purposes only, and shall not be rented in whole or in part for transient lodging purposes, boarding house, "bed and breakfast," or other uses for providing commercial accommodations. No lease of any Dwelling shall be for a period of less than 30 days. No Dwelling on a Lot shall be subjected to time interval or time fractional ownership.

- 2.16 <u>Re-Subdivision.</u> No Lot may be re-subdivided without the consent of the Committee, and no resubdivision of any Lot may result in the construction of any additional Dwellings within the Lot.
- Recontouring, Excavation and Grading. No lot shall be recontoured, excluding grading for purposes of basement construction, without the prior written approval of the Committee. Among other matters, the Committee's approval may be conditioned on the requirement that the proposed grading conform to the general grading plan applicable to the Property (the "General Grading Plan"). Plans for excavation, grading and installation of rock retaining walls shall be submitted to the Committee at the time of submission of construction plans, in accordance with the provisions of Article VI. Anywhere cuts exceed a 3 to 1 slope, Lot Owners shall do one of the following until the disturbed area is properly revegetated: (i) use silt fencing, (ii) use erosion blankets, or (iii) as approved by the Committee, construct a decorative wall or use natural rock retaining walls. All disturbed areas must be covered with natural soil and planted with grasses or other appropriate plant material. Owners must retain or mitigate cuts or fills that impact adjacent Lots. Owners are fully responsible for assuring drainage issues and flood control are handled appropriately and mitigated during grading, excavation and construction to avoid flooding of neighboring Lots and to avoid flooding of the Owner's own construction site and Dwelling. Each Owner is fully responsible for grading his or her Lot to the required specifications, and shall have no claims against Declarant for any drainage on or off the Lot or flooding. Each Lot Owner shall be responsible for minimizing surface water run-off within his or her own Lot boundaries. Lot Owners should consider installation of French drains in locations where drainage may be at issue or problematic. All grading associated with construction of a Dwelling shall be completed prior to occupancy.
- 2.18 <u>Drainage</u>. In addition to the requirements set forth in the preceding provision, no Owner shall alter the direction of natural drainage from his or her Lot, nor permit accelerated storm run-off to leave his or her Lot without first using reasonable means to dissipate the flow and mitigate the run-off. Each Owner shall require his or her builder to deliver finished grades to streets and other common water carriers (such as trails, paths, creeks, canals or ditches) as set forth on the General Grading Plan.
- 2.19 <u>Sewer Connection Required.</u> All Lots are served by sanitary sewer service, and no cesspools, septic tanks, or other types of waste disposal systems are permitted on any Lot. All Dwelling units must be connected to the sanitary sewer system.
- 2.20 <u>Trash and Rubbish.</u> All Lots (improved or unimproved) shall be kept free of rubbish, weeds, and other unsightly items, and shall be maintained in such a manner as not to detract from the residential quality of the Property. Trash, rubbish, garbage or other waste shall not be kept except in covered containers. Garbage and trash receptacles shall be permitted when kept in a visually screened enclosure, such that the garbage and trash receptacles are not visible from the improved roads within the Property.
- 2.21 <u>Vehicles Restricted to Roadways.</u> No motor vehicle will be operated on the Property except on improved roads and driveways. No snowmobiles or motorcycles will be operated on any Lot except for ingress and egress or while loading the equipment for lawful transport on public streets. No vehicle parking shall be permitted on front or visible side yards other than on designated driveways.
- 2.22 Overnight Parking and Storage of Vehicles. The storage of any automobiles, trucks, buses, tractors, trailers, camping vehicles, boats, boat trailers, snowmobiles, mobile homes, two and three wheeled motor vehicles, or other wheeled motor vehicles shall be parked behind 6 ft. fence located behind the front corner of the home and shall be stored on a concrete pad.

2.23 <u>Kennels.</u> No kennel or dog run may be placed or maintained closer than 50 feet to any Dwelling other than the Dwelling on the Lot where the kennel or dog run is maintained.

ARTICLE III COMMITTEE

It is the intention and purpose of this Declaration to impose architectural standards on the Improvements to any Lot of a type and nature that result in buildings which are architecturally compatible in terms of lot coverage, proportion, materials, colors and general appearance, while at the same time allowing for appropriate diversity in style and design. To accomplish this goal, the Declarant hereby establishes the Committee, which is empowered to oversee and enforce the Architectural Design Standards set forth in this Declaration.

- 3.1 <u>Committee Composition.</u> The architectural control committee (the "Committee") will consist of three members, who may or may not be Owners. The Committee shall be appointed by the Declarant or its successor, in its sole discretion. The right to select Committee members also includes the right to remove one or more members of the Committee and to fill vacancies. The Committee shall act by a majority vote of those present in any meeting duly called for conducting official business.
- 3.2 Approval by Committee Required. No Improvements of any kind, including without limitation the construction or installation of any Dwelling, garage, guest house, outbuilding, parking enclosure, driveway, tennis court, walkway, deck, gazebo, basketball court, any hard surfaced area in excess of 100 square feet, swimming pool, outdoor hot tub or spa, fence, wall, curb, trampoline, satellite dish or antenna, solar panel, or any other permanent or temporary structure, may be constructed, erected, or installed in the Property or on or within any Lot without the prior written consent of the Committee. No excavation, grading, filling, draining, landscaping, shall be made without the advance written consent of the Committee. Approval of the Committee will be sought in the following manner:
- (a) Plans Submitted. Plans for the construction of any new Dwelling must be submitted to the Committee for review. It is recommended that a preliminary plan be submitted before the expense of final construction drawings is incurred. The plan must be in sufficient detail to show the location on the Lot of the exterior walls of the Dwelling and all other structures to be built with it; detailed drawings of all elevations of all buildings showing locations of windows, doors, roof pitches, decks and other exterior elements; a list of exterior materials and roofing materials and/or a sample, including color samples; and a landscaping plan showing the location of landscaped areas, fences (including fence design), driveways, walkways, patios, decks and other hard surfaced or irrigated areas. In the case of an addition or modification of an existing Dwelling, the Committee may waive any of the forgoing it determines to be unnecessary for its review. Notwithstanding any review and approval of plans by the Committee, each Owner shall be responsible for the design and placement of improvements on Lots to avoid damage from ground and drainage water, and neither the Committee nor the Developer shall have any responsibility or liability with respect thereto.
- (b) Review Fee. The applicant will pay a review fee to the Committee in an amount reasonably necessary to cover the costs of review and the administration of the program in an amount to be established from time to time by the Architectural Committee. Currently there is no review fee.
- (c) <u>Review.</u> Within 15 days from receipt of a complete submission, the Committee will review plans and make an initial determination whether or not the plans comply with the conditions imposed by the

Declaration. If they do not, the plans will be rejected. If they are in compliance, the Committee will approve the plans. The Committee may also approve the plans subject to specific modifications or conditions. Owners may desire to submit preliminary plans for review. The committee will review preliminary plans, without fee, and make its comments known to the Owner provided, however, that no preliminary approval is to be considered a final approval, and no final approval will be granted on less than a complete submission. Upon approval, the Committee and the Owner will each sign a copy of the plans, which shall be left with the Committee. Construction that is not in strict compliance with the approved plans will not be permitted.

- (d) <u>Written Record.</u> The Committee will maintain a written record of its actions, and maintain in its files a copy of all plans approved or rejected for a period of five years.
- (e) <u>Failure to Act.</u> If the Committee has not approved or rejected any submission within 15 days after payment of the review fee and submission of complete plans, the submission is deemed to have been disapproved.
- 3.3 <u>Variances.</u> Variances to the design standards contained in this Declaration may be granted in the sole discretion of the Committee, but only if strict application of the design standards would create an unreasonable hardship to the Owner of any Lot. The Committee cannot grant any variance that has the effect of modifying applicable zoning or building code regulations.
- 3.4 <u>General Design Review.</u> The Committee will use its best efforts to provide a consistent pattern of development, and consistent application of standards of this Declaration. These standards are, of necessity, general in nature, and it is the Committee's responsibility to apply them in a manner that results in a high quality, attractive, and well designed community.
- 3.5 <u>Declarant and Committee Not Liable.</u> There shall be no liability imposed directly or indirectly on any member of the Committee for any loss, damage, or injury arising out of or in any way connected with the performance of the duties of the Committee unless due to the willful misconduct or bad faith of such member. In reviewing any matter, the Committee shall not be responsible for reviewing, nor shall its approval of any building, structure, or other item be deemed approval of, the building, structure, or other item from the standpoint of safety, whether structural or otherwise, or conformance with building codes or other governmental laws or regulations.
- 3.6 <u>Limitations on Review.</u> The Committee's review is limited to those matters described in this Declaration. The Committee shall have no responsibility to enforce building codes, zoning ordinances, or other statutes, laws, or ordinances affecting the development or improvement of real property and shall have no liability to any Owner whose plans were approved in a manner that included any such violation.

ARTICLE IV ARCHITECTURAL RESTRICTIONS

All Improvements on any Lot shall be subject to the following restrictions and design standards:

- 4.1 <u>Number of Dwellings.</u> Only one single family residence may be constructed on any Lot. All Dwellings shall have an attached garage for at least three (3) cars.
- 4.2 <u>Barns and Out Buildings.</u> Barns, out buildings and all other storage buildings must conform to the Dwelling on the Lot in style and materials, including roof material.

- 4.3 <u>Dwelling Size.</u> Dwelling size requirements are as follows:
 - a. <u>A Rambler, One-story home</u> shall have not less than 1,700 square feet of space on the main floor.
 - b. <u>A two-story home</u> shall have not less than 2,100 square feet of finished living area. In the Committee's review of plans for any two-story home, particular attention to the design of the rear of the home shall be required.
- 4.4 <u>Dwelling Height and Width.</u> Will comply with city code.
- 4.5 <u>Dwelling Setback and Placement.</u> Will comply with city code
- Exterior Requirement. The exterior design and materials of all dwellings must be of sufficient quality, durability, and resistance to the elements to satisfy the International Building Code. Brick, stone, stucco or fiber cement is required on the exterior walls of all residential buildings, the location and placement of such materials being left to the discretion of the builder or owner. The minimum required amount of brick, stone, stucco, fiber cement, or combination thereof is 40% of the front elevation, except when doing a craftsman or prairie style home 100% will be required on the front elevation. New materials that have the quality, look, desirability and resistance to the elements comparable to brick, tile, stone, stucco or fiber cement may be approved by the Committee. A three (3) ft. wrap or return on each side of the home will be required, unless otherwise approved in advance by the Committee. The color of all masonry used shall be disclosed to the Committee and Owners are encouraged to submit samples. The use of metal soffit or facia sections is encouraged. Exposed cement foundation height shall average not more than 18" above finished grade on all sides. Wainscot is acceptable. Wood exteriors are not permitted. White trim is permitted but white, bright, or dramatic colors shall not be used as primary exterior colors. All exterior colors and materials must be approved by the Committee prior to installation or application.
- 4.7 Roof Design. Roof pitches must be within a range of 5/12 to a 12/12 slope unless otherwise approved by the Committee. All roofs shall be pitched. All roofing materials must be of architectural grade asphalt shingles or better, i.e. shake, tile, etc., as approved by the Committee. Mansard, fake mansard, A frame, gambrel, flat, curve-linear, and domed roof designs are prohibited. All roof metal such as flashing, vent stacks, gutters, and chimney caps shall be made of anodized aluminum or galvanized metal painted to match the adjoining roof color.
- 4.8 <u>Windows.</u> All windows must be at least double glazed. Any trapezoidal window must follow the shape of the walls or roofs surrounding them, with the top parallel to the roof above, and the bottom horizontal or parallel to the roof structure below it. No mirrored or reflective glass may be used.
- 4.9 <u>Chimney, Vents.</u> Chimneys must be enclosed in an approved material. No exposed metal flues are permitted. Vent stacks must be combined to the extent possible to minimize the number of roof penetrations, and should generally be place on the rear side of the roof to avoid visibility from the street. Where they are visible from the street they must be painted to conform with the color of the roofing material.
- 4.10 <u>Antennas.</u> All antennas must be enclosed within the Dwelling. Satellite dishes shall not exceed three feet in height and must be located and screened in a manner approved in advance by the Committee so that they are not directly visible from the street in front of the Dwelling. No satellite dishes shall be located in visible front or side yards. Solar panels will be permitted only with the consent of the Committee, and if

permitted at all, must lie flat against the roof and may not differ in pitch or color from the roof surface on which they are mounted. No antenna of any sort which is visible from the front of neighboring properties shall be allowed.

- 4.11 <u>No Used or Temporary Structures.</u> No previously erected, used, or temporary structure, mobile home, trailer house, or any other non-permanent structure may be installed or maintained on any Lot. No metal building or metal storage sheds are allowed.
- 4.12 <u>Balconies, Decks & Covered Patios.</u> Any balcony, deck or Covered Patio that is more than twenty-four inches above the natural grade must be constructed in compliance with the following: All posts, pillars and columns supporting any deck must be between eight and sixteen inches in width. All posts, pillars and columns must be furred out and fully sheathed with stone or stucco unless approved by commettie. All handrails must be made of iron, synthetic vinyl, PVC composite or timber frame. Any other materials must be approved in advance by the Committee before installation or use. The area under any ground-level deck must be either landscaped or screened from view so that there is no view of the underside of the deck from adjoining Lots or from the street. The area under any deck shall not be used for storage of equipment, firewood, building material, or similar material. The underside of any deck that is exposed (as in the case of a second story deck or balcony) must be finished and painted or stained.
- 4.13 <u>Driveways.</u> Every garage shall be serviced by a driveway, which shall be of sufficient width and depth so as to park three (3) vehicles side by side completely out of the street right of way.
- 4.14 <u>Ground Water.</u> In the event the Declarant or any other party installs a ground water drainage system for any portion of the Property, Owners shall be required to obtain the approval of the Committee prior to diverting water in to such system.

ARTICLE V CONSTRUCTION COVENANTS

In order to minimize the inconvenience to neighboring Owners during periods of construction within the Property, the following construction regulations shall be enforced. These regulations shall be made a part of the construction contract between the Owner and the Builder of each Dwelling or other Improvements on a Lot. The Owner shall be bound by these regulations, and violations committed by the Builder or its employees, subcontractors or others shall be deemed a violation by the Owner for which the Owner is liable.

- 5.1 <u>Portable Office or Trailer.</u> A builder or general contractor constructing a home on a Lot may utilize a portable office or trailer during the construction period only. The portable office must be located within the Owner's Lot. The temporary office may not be installed prior to the commencement of construction, and must be removed upon the first to occur of: (1) the issuance of a Certificate of Occupancy, (2) the termination, expiration, or cancellation of the Building Permit, (3) the suspension of construction activities for a period of 60 days, or (4) one year after the commencement of construction.
- 5.2 <u>Construction Debris Removal.</u> The Builder must comply with City ordinances requiring the placement and maintenance of a trash container or dumpster on the Lot. The Builder shall collect trash at the end of each work day and deposit construction trash, packing material, unusable scraps, and other debris in a suitable container, protected from the wind, and regularly serviced. No trash may be burned, buried, or otherwise disposed of within the Property. Concrete trucks may not be cleaned out on the Lot or elsewhere within the Property.

- 5.3 <u>Construction Area Appearance.</u> The Lot must be maintained in a reasonably organized and neat condition at all times during the construction of a Dwelling or other Improvements. Once the Dwelling is enclosed, materials shall be stored inside, and out of sight, whenever practical and possible.
- 5.4 <u>Sanitary Facilities.</u> The Builder is responsible for the installation and maintenance of an approved portable toilet facility during construction.
- 5.5 <u>Construction Sign.</u> During periods of actual construction on the Dwelling, the Owner or Builder may install a sign not to exceed sixteen square feet (4 x 4) in area identifying the Lot and the Builder. The sign must also comply with any sign ordinance enacted by the City after the date of this Declaration. The sign must be removed upon completion or abandonment of construction.
- 5.6 <u>Hours of Work.</u> Daily working hours on the site shall be limited to the period beginning at 7:00 AM and ending at 9:00 PM, or such lesser period as is allowed by City ordinances. The Builder is responsible for controlling noise emanating from the site.
- 5.7 Removal of Mud. The Builder is responsible for cleaning up and removing mud that is deposited on the roadways of the Property by their construction operation as required by their Best Maintenance Practices (BMP's) noted in their SWPPP. The Builder is to indemnify the Declarant and or Developer if fines are levied by any government or quasi government agency for mud or debris.
- Duration of Construction. No construction shall occur without a building permit and all other necessary permits from the City and any other governmental entity having jurisdiction over construction on the site. No materials, tools, temporary offices or portable toilets, excavation or construction equipment, or similar materials or equipment may be delivered to this site prior to the issuance of the building permit. It is the obligation of the Owner to complete construction with all reasonable speed once construction has commenced, and in any event, all exterior surfaces of the building shall be substantially completed within a period of twelve (12) months from the date that the foundation is complete. All landscaping and soil stabilization work must be completed as soon as possible after completion of the exterior of the Dwelling, but in no event later than the summer following completion of the exterior of the Dwelling.

ARTICLE VI LANDSCAPE STANDARDS

It is the intent of the Declaration to require appropriate landscaping of Lots following construction of any Improvements, and to encourage the use of appropriate plant materials. The use and Improvement of each Lot is subject to the following Landscape Standards:

- 6.1 <u>Lawn and Landscaping Required.</u> Front yard and visible side yard lawns and landscaping must be installed before occupancy. Trees, lawns, shrubbery and other plantings provided by each Owner shall be properly nurtured and maintained at the Owner's sole expense, including replacement of the same at the Committee's request. If a home is complete and ready to occupy the owners/builders may post a bond with the City of Herriman to insure the completion of the landscape.
- 6.2 <u>Placement of Trees and Shrubs; Concrete Edging.</u> The Lot Owner is required to plant and maintain

at least 2 2 inch caliber Green Spire Lindon trees in the parking strip between the back of the curb and the sidewalk in front of his or her Lot. A minimum of 2 1.5 inch caliber trees and 8 shrubs beyond what is included in the park strip will be required in the front yard landscaping.

- 6.3 <u>Sprinkler System.</u> All landscape and lawn areas, including those in the landscape strip, shall be provided with permanent underground sprinkler systems.
- 6.4 <u>Fences.</u> Shall comply with Herriman City's fencing ordnance. If Vinyl, we recommend tan in order to create consistency.
- 6.5 <u>Fires.</u> No exterior fires whatsoever, except barbecue fires contained in receptacles provided therefor, shall be allowed.
- 6.6 <u>Compaction.</u> Each Owner shall be responsible for his, her, or its Lot to ensure adequate compaction of soil and fill materials under all footings, structural, and flat concrete areas and to ensure adequate compaction under all lawn and landscaped areas.

ARTICLE VII OWNERS' OBLIGATIONS

- 7.1 <u>Duty to Install and Maintain.</u> The Owner of each Lot shall maintain his or her Lot and the Improvements thereon in a good state of repair and an attractive, safe, and healthy condition, as required by the provisions of Section 2.9 and elsewhere in this Declaration. The Owners of each Lot shall also comply with the landscaping installation and maintenance requirements set forth in Article VI above. The remaining provisions of this Article VII are intended to secure the timely performance of all such obligations.
- 7.2 <u>Alteration of Exterior Appearance</u>. The Owners will maintain their Lots and Improvements in substantially the same condition and appearance as that approved by the Committee. No subsequent exterior alterations, improvements or remodeling, whether structural or changes in landscaping, paint color or materials will be made without the advance consent of the Committee.
- 7.3 Repair Following Damage. In the event of casualty loss or damage to the Improvements, the Owner will be entitled to reconstruct the Improvements as they existed prior to the damage or loss without review by the Committee, provided however that alterations or deviations from the original approved plans will require review. Nothing in this Declaration is intended to prevent an Owner who has suffered property damage or loss from taking temporary measures to secure the property and prevent further damage, or to prevent injury or dangerous conditions following loss or damage, before reconstruction begins. Such temporary measures may be taken without the consent or approval of the Committee, provided that any such measures must be of a temporary nature, and repair or reconstruction must begin as soon as circumstances will permit. No damaged structure will be permitted to remain on any Lot for more than ninety (90) days without repairs commencing, and any damaged structure which remains unrepaired after 90 days following the occurrence

of damage shall be deemed a nuisance.

7.4 Storm Water Permits. All Owners who acquire title to a Lot (whether the Owner is a builder, individual person, entity or otherwise) shall obtain their own Storm Water Permits (as defined in Article I above) from the Division of Water Quality (Utah Department of Environmental Quality) prior to commencing any construction-related activities for which a Storm Water Permit is required (including, without limitation, excavating, grading, or otherwise disturbing the surface materials or vegetation on the Lot). The Storm Water Permit may be obtained by filling out an application form online at www.waterquality.utah.gov/updes/stormwater.htm or contacting the Division by telephone at (801) 538-6146. All Owners who seek to engage in any construction-related activities requiring a Storm Water Permit covenant and agree to comply with the Storm Water Permit requirements, including, without limitation, the requirement to develop and implement a Storm Water Pollution Prevention Plan. In addition to the requirements and provisions of Sections 2.17 and 2.18 of this Declaration, Owners shall be fully and solely responsible for preventing rain and snowmelt from carrying sediment or pollutants into the streets or any storm drain facilities from any un-landscaped areas of their Lots. Owners covenant and agree not to stockpile any landscaping materials, dirt, gravel or other such materials in the streets. Owners other than Declarant, following their purchase of a Lot, hereby indemnify and hold Declarant harmless from and against any and all claims, liabilities, fines, costs, fees, expenses, judgments, losses and damages resulting from or relating to any failure to comply with the Storm Water Permit requirements for the Owner's Lot or from any storm water drainage or run-off from Owner's Lot, including, without limitation, any and all claims, fines, costs of remediation or clean up, or other expenses imposed by the Division or required or incurred as a result of any action or orders of the Division.

ARTICLE VIII FIRST MORTGAGEES

8.1 <u>First Mortgagee Protection.</u> The breach of any of the foregoing covenants shall not defeat or render invalid the lien of any mortgage or deed of trust lien on the Property that is made in good faith and for value; provided, however, that all of the covenants contained herein shall be binding upon and effective against any owner of a Lot whose title thereto is acquired by foreclosure, trustee's sale or other foreclosure proceeding, from and after the date of such foreclosure, trustee's sale or other foreclosure proceeding.

ARTICLE IX GENERAL PROVISIONS

9.1 <u>Violation Deemed a Nuisance</u>. Any violation of these Covenants which is permitted to remain on the property is deemed a nuisance, and is subject to abatement by the Association or by any other Owner.

9.2 Remedies.

(a) Any single or continuing violation of the Covenants contained in this Declaration may be enjoined in an action brought by the Declarant (for so long as the Declarant is the Owner of any Lot), by any other Owner, or by the Committee in its own name. In any action brought to enforce these Covenants, the prevailing party shall be entitled to recover as part of its judgment the reasonable costs of enforcement, including attorney fees and costs of court.

- (b) Nothing in this Declaration shall be construed as limiting the rights and remedies that may exist at common law or under applicable federal, state or local laws and ordinances for the abatement of nuisances, health and safety, or other matters. These covenants, conditions and restrictions are to be construed as being in addition to those remedies available at law.
- (c) The remedies available under this Declaration and at law or equity generally are not to be considered exclusive, but rather as cumulative.
- (d) The failure to take enforcement action shall not be construed as a waiver of the Covenants contained in this Declaration in the future or against other similar violations.
- 9.3 <u>Severability.</u> Each of the covenants, conditions and restrictions contained in this Declaration shall be independent of the others, and in the event that any one is found to be invalid, unenforceable, or illegal by a court of competent jurisdiction, the remaining provisions shall remain in full force and effect.
- 9.4 <u>Limited Liability.</u> Neither the Declarant, the Committee or its individual members, nor any other Owner shall have personal liability to any other Owner for actions or inactions taken under these Covenants, provided that any such action or inaction is the result of the good faith exercise of their judgment or authority, under these Covenants, and without malice.
- 9.5 <u>Amendment.</u> At any time while this Declaration is in effect, the Declarant may amend the provisions of this Declaration, any amendment must be in writing. When the Declarant has no remaining lots in the subdivision or after the Declarant has satisfied the required warranty period and the bond has been released by the city, whichever may come last, the Declarant may assign their rights under this declaration, including the rights of the Committee, in whole or in part, to the Owners. Upon Assignment of the Declaration of Covenants Conditions and Restrictions, the Declaration may be amended or terminated by a vote of at least seventy-five percent (75%) of the total votes of all Home Owners, (one vote per homeowner), which vote shall be taken at a duly called meeting. Any amendment approved shall be reduced to writing, signed and recorded against the lots.
- 9.6 <u>Constructive Notice.</u> Every person who owns, occupies, or acquires any right, title or interest in any Lot in the Property is conclusively deemed to have notice of this Declaration and its contents, and to have consented to the application and enforcement of each of the covenants, conditions and restrictions contained herein against his Lot, whether or not there is any reference to this Declaration in the instrument by which he acquires his interest in any Lot.
- 9.7 <u>Notices.</u> All notices under this Declaration are deemed effective seventy-two (72) hours after mailing, whether delivery is proved or not, provided that any mailed notice must have postage prepaid and be sent to the last known address of the party to receive notice. Notices delivered by hand are effective upon delivery.
- 9.8 <u>Interpretation.</u> The provisions of this Declaration shall be interpreted liberally to further the goal of creating a uniform plan for the development of the Property. Paragraph headings are inserted for convenience only and shall not be considered an interpretation of the provisions. The singular will include plural, and gender is intended to include masculine, feminine and neuter as well.

EXECUTED BY THE DECLARANT:

Herriman Ridge Properties, LLC., a Utah Limited



	Date of Meeting: 01/21/16	
File #	38S15	
Applicant	Edge Homes	
Address	13295 S Herriman Rose Blvd	
Request	Proposed Subdivision of Single Family Cluster Units and Condos	

Request for 38S15/14C08-19 - Meeting Date 1/21/2016

Edge Homes is requesting a subdivision of 88 Single Family Cluster units and 60 Condo units.

Site

The parcel is located at 13295 S Herriman Rose Blvd and contains 11.64 acres.

Zoning

The site is zoned MU-2.

This property is part of the Herriman Towne Center. The entire project received preliminary approval in 2008 and each pod comes in for final approval. The HTC is approved at a minimum density of 5.5 units per acre overall, which is 2,032 units. They have received final master plan approval for 1,358 units in the HTC, which leaves 674 units that they need to build in order to meet their minimum density requirement.

Issues

The project is proposed at 12.7 units per acre. The units are planned to be condos and single family units. The condos will be "for sale", not for rent. The applicant has submitted building elevations for your review and approval.

Part of the property is adjacent to the future UTA mass transit line. Staff is proposing a 2 rail vinyl fence to help delineate the future transit corridor. This property will be open space until a transit line is built in the future. UTA will likely install a sound wall with the construction of the transit line.

The ordinance requires 2 parking spaces per unit, however the MU-2 zone allows for a 5 percent reduction in parking due to the location of the transit station. The MU-2 zone also requires that projects not provide more than 120% of the required parking. The proposed units each have a single car garage and a driveway. The plan also has 10 off street parking stalls and 72 on street stalls. The on street parking will be striped and signed as visitor only. This totals 2.81 parking spaces per unit.

The applicant has submitted the same building elevations and color schemes that were recently approved in the adjacent phase of the HTC. They would like to have the same building elevations approved for this phase.

Recommendation

Staff recommends subdivision and final master plan approval of 60 condo units and 88 single

family cluster units with the following requirements:

Subdivision Requirements

- 1. Meet with the Staff for review and final approval of the site plan.
- 2. Receive and agree to the recommendations from other agencies.
- 3. Install curb, gutter and sidewalk on all public streets.
- 4. Provide 100 year storm detention. This can be provided off-site as part of the Towne Center detention.
- 5. Provide a traffic study.
- 6. The alleys for the single family units should line up with each other or be offset to meet city standards.
- 7. The approval is for 60 condo units and 88 single family cluster units.
- 8. The future transit line should be shown on the plat.

Master Plan Requirements

- 1. Receive and agree to the recommendations from other agencies.
- 2. Landscaping for the condos shall be installed by the builder and maintained by the HOA.
- 3. Install a 2 rail vinyl fence along the UTA corridor.
- 4. Building elevations to meet the approved HTC design guidelines and receive ARC approval.
- 5. Building elevations and materials are approved as submitted, including the color palettes shown.
- 6. Parking for the condos should include a garage and a driveway for each unit, and at least 72 designated guest parking spaces.
- 7. The open space on the south side of the property should have a pedestrian trail connection to the development and contain a sport court that is at least 50' x 50' (2,500 square feet).
- 8. The setbacks shall be as follows:

For lots with Driveways:

18' to the garage

14' to living space

5' side yard

5' rear yard

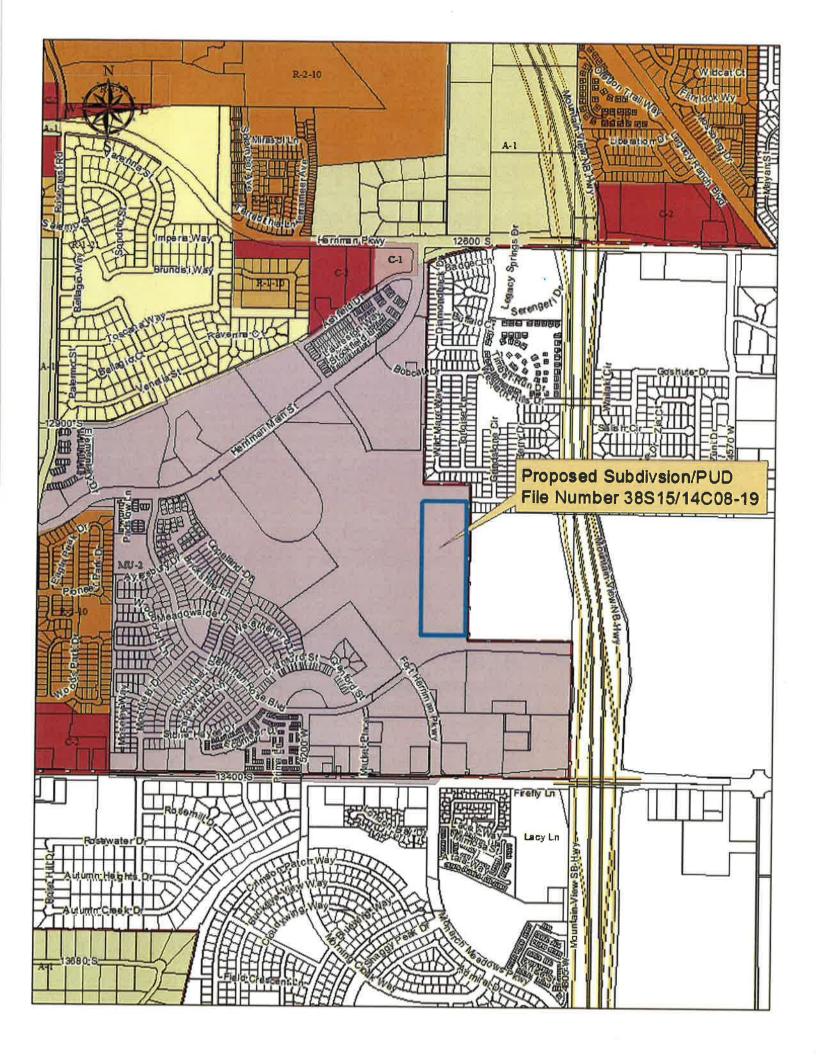
For lots without Driveways

- 5' to garage
- 3' to living space
- 5' side yard
- 5' rear yard

For Condos

18' to garage

- 10' front yard (for breezeways)10' between buildings15' side yard10' rear yard

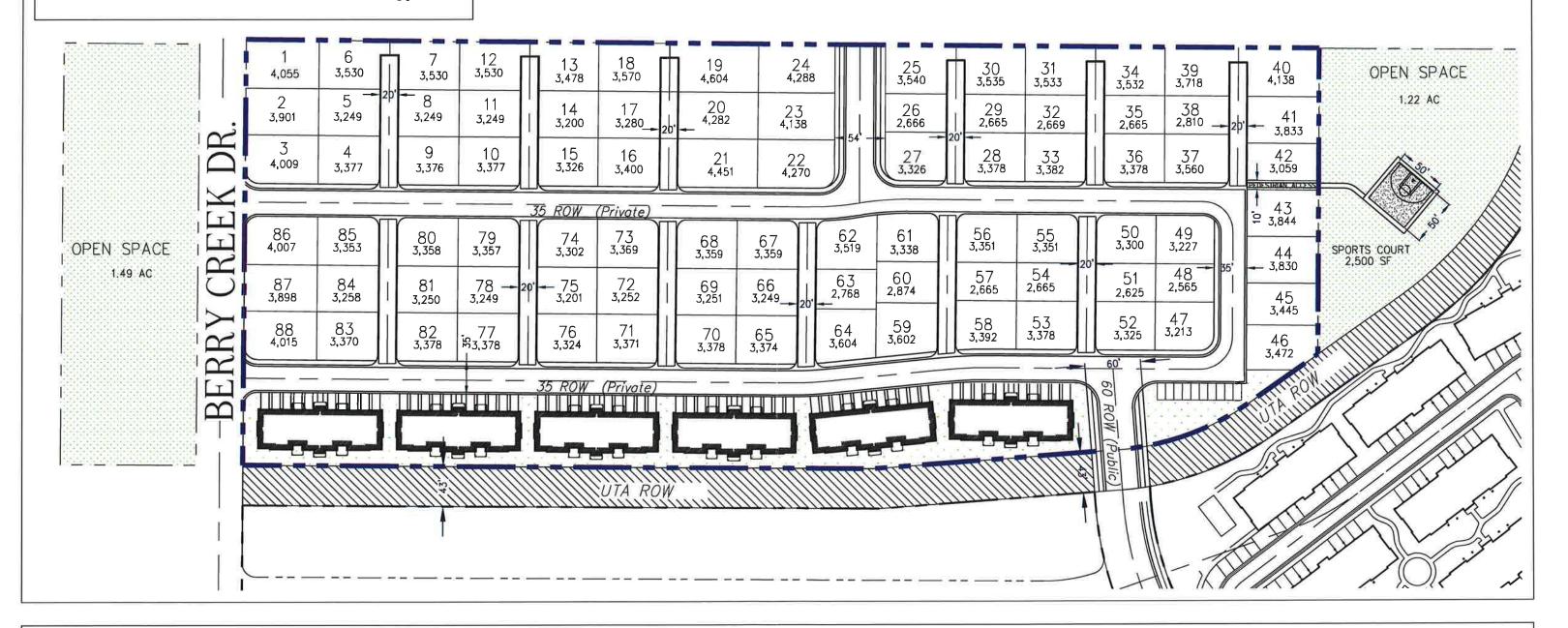


POD 26 LAND USE SUMMARY

11.64 AC PROJECT AREA SINGLE FAMILY CLUSTER UNITS **CONDO UNITS** 12.7 DU/AC PROJECT DENSITY **OPEN SPACE** 33% (condo unit only) AVG. LOT SIZE 3,422 SF ON STREET PARKING 72 OFF STREET PARKING

10

TOWER PROPERTY



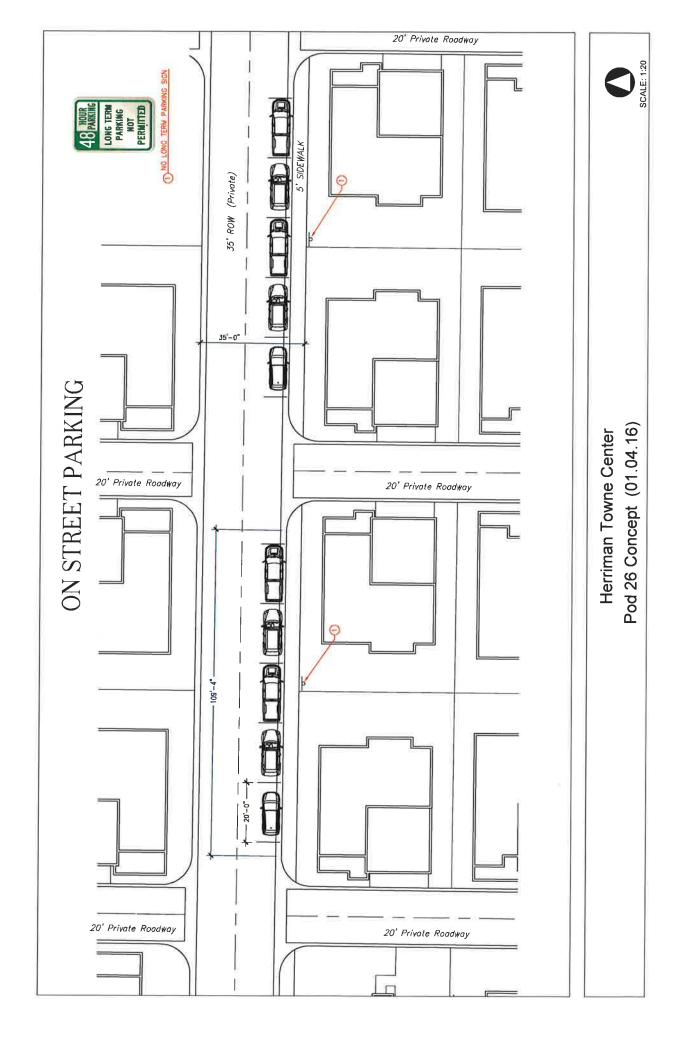
Herriman Towne Center Pod 26 Concept (01.05.16)





Herriman Towne Center
Pod 26 Parking Exhibit (12.23.15)







Address or location of site (No Post Office Box #)13295 S Herriman Rose BLVD
Size of Parcel11.64 Acres
What is Requested (explain in detail)?
To subdivide a parcel of land into 88 Single Family Cluster units
and 60 condo units.
If applicable, square footage of proposed building(s) or addition (all stories combined)
If the request is residential, how many and what type of units (apartment, condo, etc). 60 Condo 88 Single Family Property Owner's Name HTC Communities LLC
Mailing Address 10421 S Jordan Gateway Blvd #200, South Jordan 84095
Telephone (801) 316-3214 Cell Number E-mail matt@mdevg.com
Applicant Edge Homes - Steve Maddox
Mailing Address 482 West 800 North Ste 200 Orem, UT 84057
Telephone (801) 494-8869 Cell Number E-mail steve@edgehomes.com
Subject to Purchase or Lease: X or Present Owner of Property:
Yes I am the authorized agent or owner of the subject property:
Current Use of Subject PropertyVacant
Proposed Development Name Copper View (HTC Pod 26)
For Herriman Use Only
Check Number Date of Submittal File Number SS 5
Filing Fee \$5,440 Receipt Number Accepted by

Phone: (801)446-5323 Email: planning@herriman.org



	Date of Meeting: 01/21/16
File #	14C08-19
Applicant	Edge Homes
Address	13295 S Herriman Rose Blvd
Request	Final Master Plan Approval of Single Family Cluster Units and Condos

Request for 38S15/14C08-19 - Meeting Date 1/21/2016

Edge Homes is requesting a subdivision of 88 Single Family Cluster units and 60 Condo units.

Site

The parcel is located at 13295 S Herriman Rose Blvd and contains 11.64 acres.

Zoning

The site is zoned MU-2.

This property is part of the Herriman Towne Center. The entire project received preliminary approval in 2008 and each pod comes in for final approval. The HTC is approved at a minimum density of 5.5 units per acre overall, which is 2,032 units. They have received final master plan approval for 1,358 units in the HTC, which leaves 674 units that they need to build in order to meet their minimum density requirement.

Issues

The project is proposed at 12.7 units per acre. The units are planned to be condos and single family units. The condos will be "for sale", not for rent. The applicant has submitted building elevations for your review and approval.

Part of the property is adjacent to the future UTA mass transit line. Staff is proposing a 2 rail vinyl fence to help delineate the future transit corridor. This property will be open space until a transit line is built in the future. UTA will likely install a sound wall with the construction of the transit line.

The ordinance requires 2 parking spaces per unit, however the MU-2 zone allows for a 5 percent reduction in parking due to the location of the transit station. The MU-2 zone also requires that projects not provide more than 120% of the required parking. The proposed units each have a single car garage and a driveway. The plan also has 10 off street parking stalls and 72 on street stalls. The on street parking will be striped and signed as visitor only. This totals 2.81 parking spaces per unit.

The applicant has submitted the same building elevations and color schemes that were recently approved in the adjacent phase of the HTC. They would like to have the same building elevations approved for this phase.

Recommendation

Staff recommends subdivision and final master plan approval of 60 condo units and 88 single

family cluster units with the following requirements:

Subdivision Requirements

- 1. Meet with the Staff for review and final approval of the site plan.
- 2. Receive and agree to the recommendations from other agencies.
- 3. Install curb, gutter and sidewalk on all public streets.
- 4. Provide 100 year storm detention. This can be provided off-site as part of the Towne Center detention.
- 5. Provide a traffic study.
- 6. The alleys for the single family units should line up with each other or be offset to meet city standards.
- 7. The approval is for 60 condo units and 88 single family cluster units.
- 8. The future transit line should be shown on the plat.

Master Plan Requirements

- 1. Receive and agree to the recommendations from other agencies.
- 2. Landscaping for the condos shall be installed by the builder and maintained by the HOA.
- 3. Install a 2 rail vinyl fence along the UTA corridor.
- 4. Building elevations to meet the approved HTC design guidelines and receive ARC approval.
- 5. Building elevations and materials are approved as submitted, including the color palettes shown.
- 6. Parking for the condos should include a garage and a driveway for each unit, and at least 72 designated guest parking spaces.
- 7. The open space on the south side of the property should have a pedestrian trail connection to the development and contain a sport court that is at least 50' x 50' (2,500 square feet).
- 8. The setbacks shall be as follows:

For lots with Driveways:

18' to the garage

14' to living space

5' side yard

5' rear yard

For lots without Driveways

- 5' to garage
- 3' to living space
- 5' side yard
- 5' rear yard

For Condos

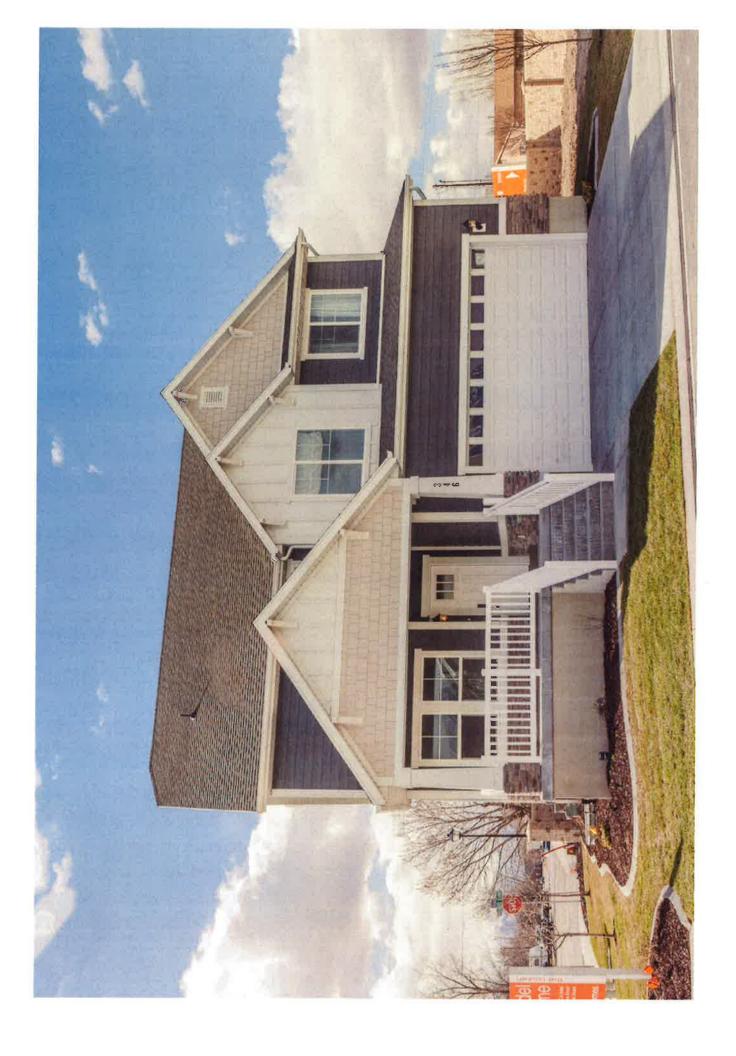
18' to garage

- 10' front yard (for breezeways)10' between buildings15' side yard10' rear yard











Address or location of site (No Post Office Box #) 13295 S Herriman Rose BLVD
Size of Parcel11.64 Acres
What is Requested (explain in detail)?
To receive final Master Plan approval for a development consisting of
88 Single Family Cluster units and 60 condo units.
If applicable, square footage of proposed building(s) or addition (all stories combined)
If the request is residential, how many and what type of units (apartment, condo, etc). 60 Condo Property Owner's Name HTC Communities LLC
Mailing Address 10421 S Jordan Gateway Blvd #200, South Jordan 84095
Telephone (801) 316-3214 Cell Number E-mail matt@mdevg.com
Applicant Edge Homes - Steve Maddox
Mailing Address482 West 800 North Ste 200 Orem, UT 84057
Telephone (801) 494-8869 Cell Number E-mail steve@edgehomes.com
Subject to Purchase or Lease: X or Present Owner of Property:
Yes I am the authorized agent or owner of the subject property:
Current Use of Subject Property Vacant
Proposed Development Name Copper View (HTC Pod 26)
For Herriman Use Only
Check Number Date of Submittal File Number 14C08-17
Filing Fee 450 Receipt Number Accepted by



	Date of Meeting:	
	01/21/16	
File #	01C16	
Applicant	Nielsen	
Address	13677 S 6315 W	
Request	Proposed Secondary Unit	

Request for 01C16- Meeting Date 1/21/16

The applicant is requesting a secondary unit within the home.

Site

The parcel is located at 13677 S 6315 W.

Zoning

The site is zoned A-.50.

Ordinance

SECONDARY UNIT WITHIN A SINGLE-FAMILY HOUSE: A living unit that is smaller than the main dwelling unit and situated within the main dwelling. One of the occupants of the dwelling must own the dwelling as their primary residence and the dwelling must maintain an appearance of a single-family dwelling.

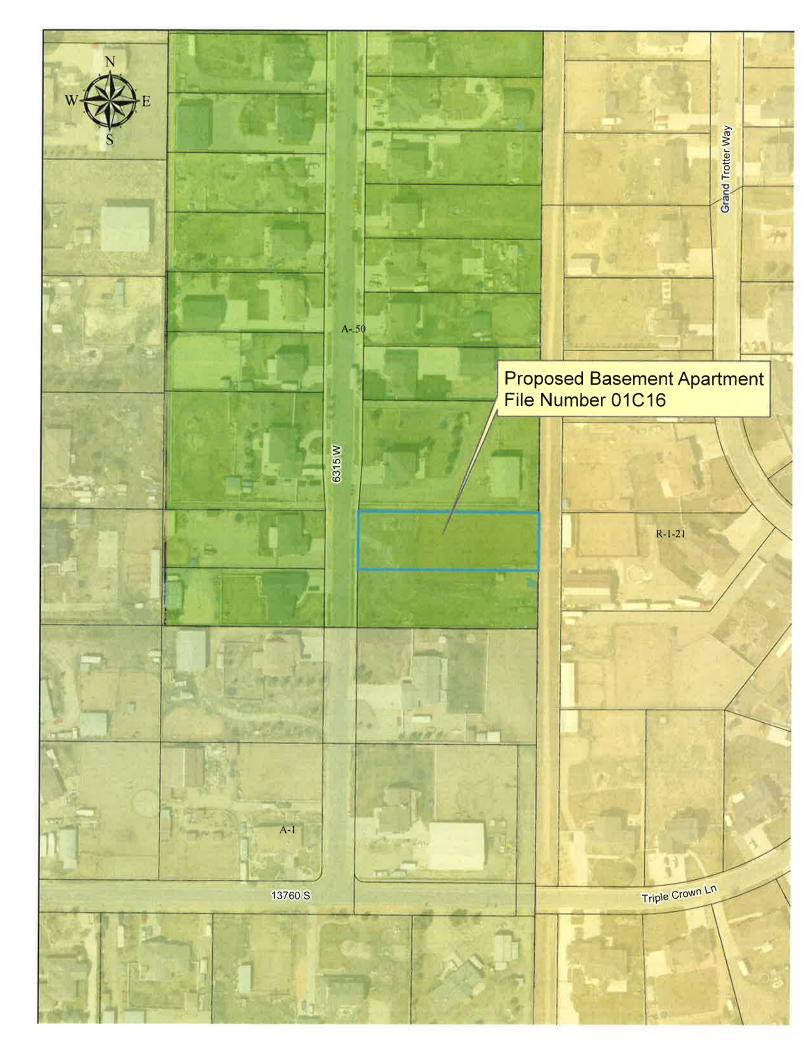
Secondary unit within a single-family house. One parking stall must be provided for the unit.

Recommendation

Staff recommends approval with the following:

Requirements

- 1. Owner must live in the home.
- 2. If the tenant has a vehicle, off street parking must be available.
- 3. Living unit must be smaller than the main dwelling unit.



Jan 21st



Land Use Application

Address or location of site (No Post Office Box #) 13677 South 6315 WEST
Size of Parcel S & ACRE
What is Requested (explain in detail)? / HAVE AN EXISTINA PERMITTED
BASEMENT APARTMENT, WITH ITS OWN ENTRANCE, THAT I
WOULD LIKE TO RENT OUT.
If applicable, square footage of proposed building(s) or addition (all stories combined)
If the request is residential, how many and what type of units (apartment, condo, etc).
Property Owner's Name Tow WIELSEN
Mailing Address 13677 SOUTH 6315 WEST, HERRIMAN, UT 84096
Telephone Cell Number 4/7-255-5782 E-mail nielsen 1 @ live.com
Applicant JON VIELSEN
Mailing Address 13677 SOUTH 6315 WEST HERRIMAN, UT 84096
Telephone Cell Number 4/7-255-5182 E-mailnielsen 1@ live .con
Subject to Purchase or Lease: or Present Owner of Property: \(\times \) \(\times \)
Yes I am the authorized agent or owner of the subject property:
Current Use of Subject Property FAMILY 1-10ME
Proposed Development Name
For Herriman Use Only
Check Number C.C Date of Submittal (-4-16 File Number DICIO
Filing Fee 150 Receipt Number 317090 Accepted by Accepted by

Phone: (801)446-5323 Email: planning@herriman.org



	Date of Meeting: 01/21/16
File #	01S16
Applicant	Rosecrest Communities, LLC
Address	14868 S Juniper Crest Rd
Request	Proposed Subdivision of Single Family Dwellings and Townhomes

Request for 01S16/01C99-15 - Meeting Date 1/21/2016

Rosecrest Communities is asking for subdivision and final PUD approval for 30 single family lots.

Site

The parcel is located at 14868 S Juniper Crest Rd and contains 14.25 acres.

Zoning

The site is zoned R-1-15.

Ordinance

11-2-2: COMPLIANCE WITH CITY GENERAL PLAN:

The lot layout, which includes the size, placement and number of lots, and street design for the subdivision that is submitted to the city for action, must comply with the intent and purpose of the general plan as adopted by the city.

General Plan

The general plan designation for this property is Single Family Residential.

Background

This property is part of the Rosecrest PUD. The entire project received preliminary approval and then each pod comes in with details for final approval.

Issues

The proposed subdivision has 30 lots. The density of this plat is 2.16 units per acre. This is planned to be a gated community. The roads will be private. They will have no sidewalks, but will allow for onstreet parking.

The subdivision only has one entrance point. The proposed plan only has 30 lots, so one access meets UFA requirements.

Recommendation

Staff recommends approval of the subdivision and PUD with 30 lots and the following requirements:

Subdivision Requirements

- 1. Meet with the Staff for review and final approval of the site plan.
- 2. Receive and agree to the recommendations from other agencies.

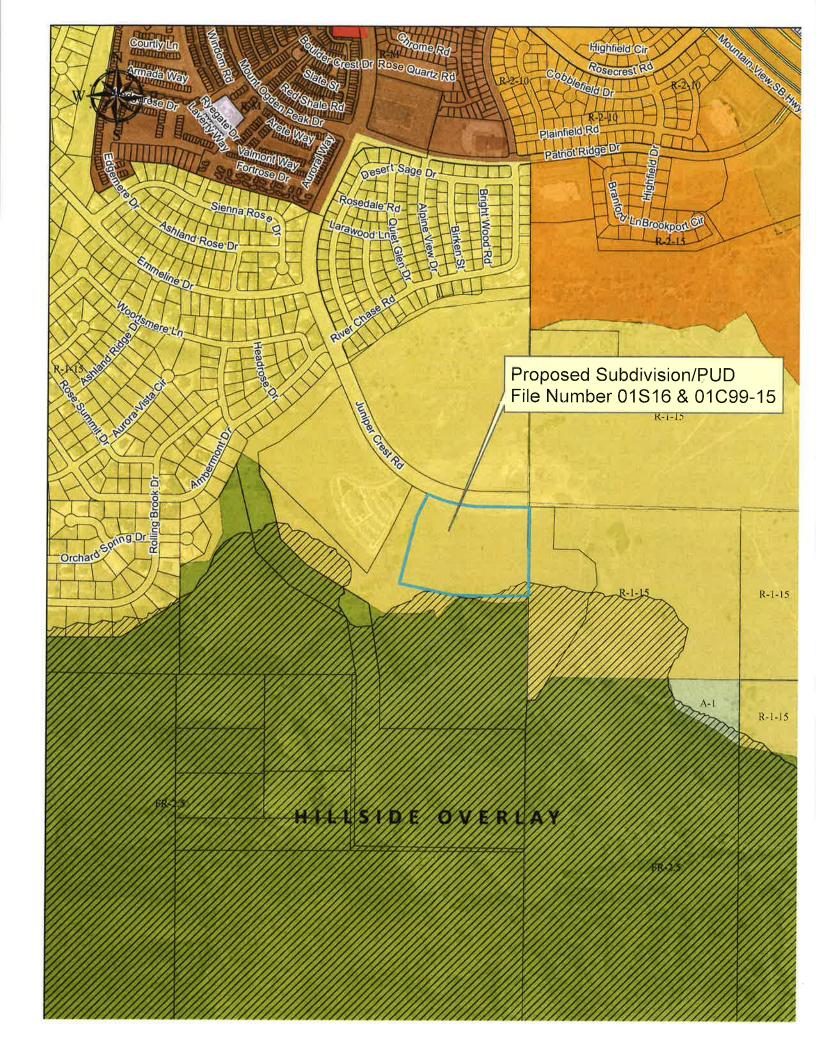
- 3. Install curb, gutter and sidewalk on all public streets.
- 4. Install a 6 foot high solid visual barrier vinyl fence along Juniper Crest.
- 5. Provide a storm drain study. Detention may be provided off-site as part of a master planned detention facility.
- 6. The number of lots approved is 30.

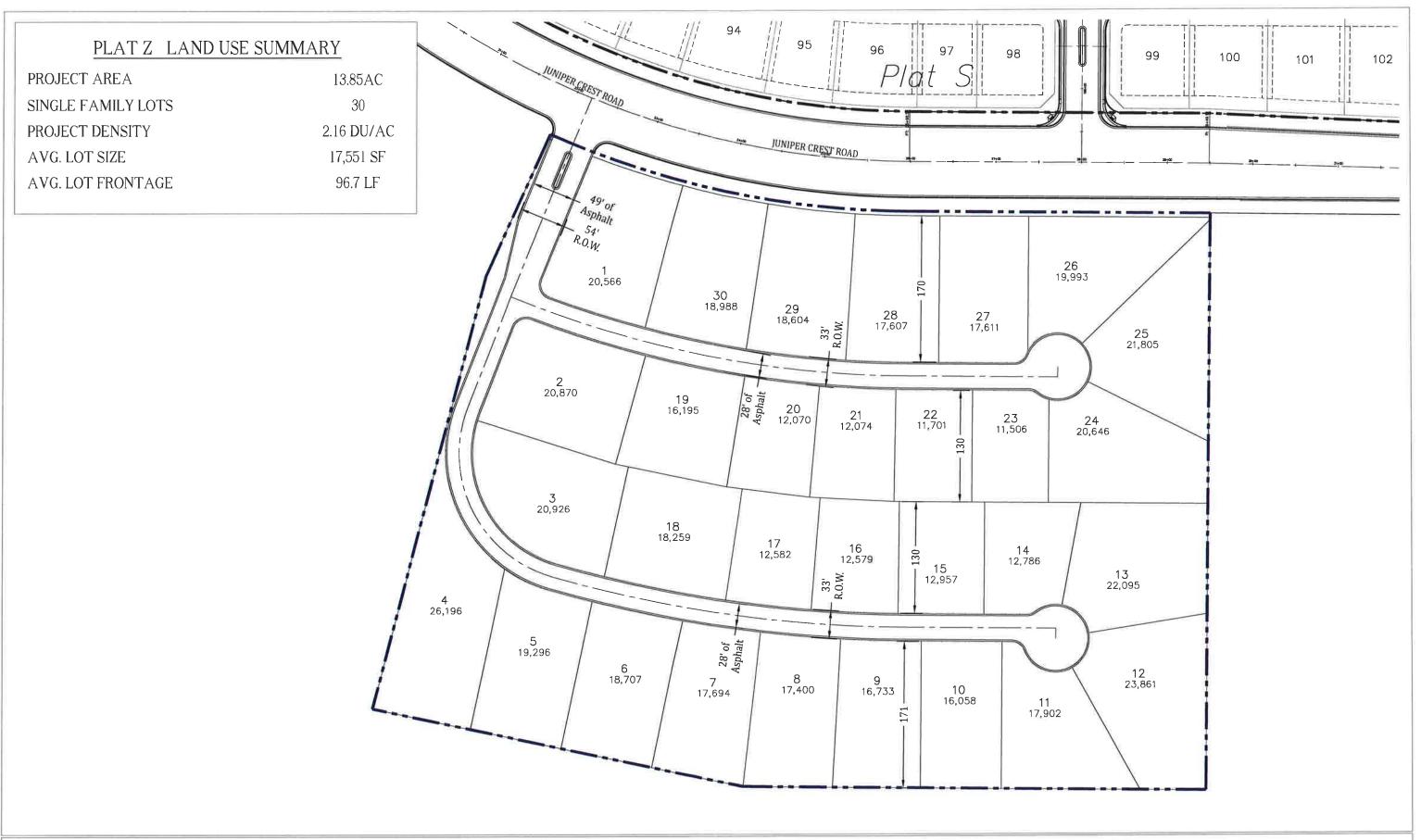
PUD Requirements

- 1. Install 15 feet of additional landscaping behind the sidewalk along Juniper Crest Road. This will be maintained by the HOA.
- 2. Setbacks will be:

Front - 19' Rear - 15' Side - 5' Corner - 19'

3. Meet the approved Rosecrest CC&R's and Design Guidelines. All building permits shall be approved by the Rosecrest ARC.





ROSECREST COMMUNITIES

Plat Z - Concept Plan (01.13.16)



Jan. 215生



Land Use Application

Address or location of site	(No Post Office Box #)	149685 Juniper Crest Rd.
Size of Parcel 14.2	Sac.	
	To sub	lots.
If applicable, square footage of	proposed building(s) or ac	ddition (all stories combined)n//
If the request is residential, how	many and what type of u	nits (apartment, condo, etc). 30 single Taunity lots
Property Owner's Name	Rosecrest-	Communities, LLC
Mailing Address	511 5 Wes	- Temple, SLC, UT 84115
Telephone 401-316-32	5 Cell Number	E-mail matter molery, com
Applicant		
Mailing Address		
Telephone	Cell Number	E-mail
Subject to Purchase or Lease: _	or Pres	sent Owner of Property:
Yes I am the authorized agent or	owner of the subject proj	perty: X
Current Use of Subject Property	A	gneulture
		st Plat Z
For Herriman Use Only	1-146	
Check Number	Date of Submittal	File Number DIGIU
Filing Fee	Receipt Number	Accepted by



Date of Meeting: 01/21/16		
File #	01C99-15	
Applicant	Rosecrest Communities, LLC	
Address	14868 S Juniper Crest Rd	
Request	Final PUD Approval for 30 Single Family Lots and Townhomes	

Request for 01S16/01C99-15 - Meeting Date 1/21/2016

Rosecrest Communities is asking for subdivision and final PUD approval for 30 single family lots.

Site

The parcel is located at 14868 S Juniper Crest Rd and contains 14.25 acres.

Zoning [Mailed Procedure]

The site is zoned R-1-15.

Ordinance

11-2-2: COMPLIANCE WITH CITY GENERAL PLAN:

The lot layout, which includes the size, placement and number of lots, and street design for the subdivision that is submitted to the city for action, must comply with the intent and purpose of the general plan as adopted by the city.

General Plan

The general plan designation for this property is Single Family Residential.

Background

This property is part of the Rosecrest PUD. The entire project received preliminary approval and then each pod comes in with details for final approval.

Issues

The proposed subdivision has 30 lots. The density of this plat is 2.16 units per acre. This is planned to be a gated community. The roads will be private. They will have no sidewalks, but will allow for onstreet parking.

The subdivision only has one entrance point. The proposed plan only has 30 lots, so one access meets UFA requirements.

Recommendation

Staff recommends approval of the subdivision and PUD with 30 lots and the following requirements:

Subdivision Requirements

- 1. Meet with the Staff for review and final approval of the site plan.
- 2. Receive and agree to the recommendations from other agencies.

- 3. Install curb, gutter and sidewalk on all public streets.
- 4. Install a 6 foot high solid visual barrier vinyl fence along Juniper Crest.
- 5. Provide a storm drain study. Detention may be provided off-site as part of a master planned detention facility.
- 6. The number of lots approved is 30.

PUD Requirements

- 1. Install 15 feet of additional landscaping behind the sidewalk along Juniper Crest Road. This will be maintained by the HOA.
- 2. Setbacks will be:

Front - 19'

Rear - 15'

Side - 5'

Corner - 19'

3. Meet the approved Rosecrest CC&R's and Design Guidelines. All building permits shall be approved by the Rosecrest ARC.



Address or location of site (N	o Post Office Box #)	1969 5 Juniper	- Crest Rd.
Size of Parcel14.25	ac.		
What is Requested (explain in	to recei		PUD apprount
If applicable, square footage of pro-	iny and what type of units (a)	partment, condo, etc).	O single Family lots
Property Owner's Name			
Mailing Address 25	11 5 West 7	emple, SLC	+ UT 84115
Telephone 401-316-3215	Cell Number	E-mail Ma	Ha mderg.com
Applicant			
Mailing Address			
Telephone	Cell Number	E-mail	
Subject to Purchase or Lease:	or Present O	wner of Property:	-
Yes I am the authorized agent or ow	mer of the subject property:	Χ	
Current Use of Subject Property	Asne	allere	
Proposed Development Name	Rosecrest	Plat Z	
For Herriman Use Only		14 (Herri)	
Check Number Da	ate of Submittal	File Number	DIC99-15
	eceipt Number		



	Date of Meeting:	
01/21/16		
File #	02S16	
Applicant	Clayton Homes, Inc	
Address	5500 W 12100 S	
Request	Proposed Subdivision of Townhomes	

Request for 02S16/38C14-03 - Meeting Date 1/21/2016

The applicant is requesting subdivision and final PUD approval for 100 townhome units.

Site

The parcel is located at approximately 5500 W 12100 S and contains 9.34 acres. This is Pod 8 on the approved PUD land use plan.

Zoning

The site is zoned R-2-10.

Background

The Miller Crossing PUD received approval in March of 2015. The approval was subject to several conditions. One of the conditions required each phase to come back to the Planning Commission for final approval.

Issues

Pod 8 is proposed at 10.7 units per acre. The approved pod is for 12 units per acre. The overall density approved in the Miller Crossing PUD is 6 units per acre.

The applicant has submitted building elevations for review and approval. The approved CCR's require a minimum of 30% of the front exterior and any side or rear viewable from a street shall be brick or stone.

The ordinance requires 2 parking spaces per unit. The proposed townhomes each have a 2 car garage. The total parking provided is 245 / 2.5 spaces per unit.

The Planning Commission should look at each phase of the PUD and attempt to incorporate the required open space in each phase. The open space is not specified on the site plan. The applicant will need to provide an open space summary for this pod.

Recommendation

Staff recommends approval of the subdivision and final PUD of 100 townhomes with the following:

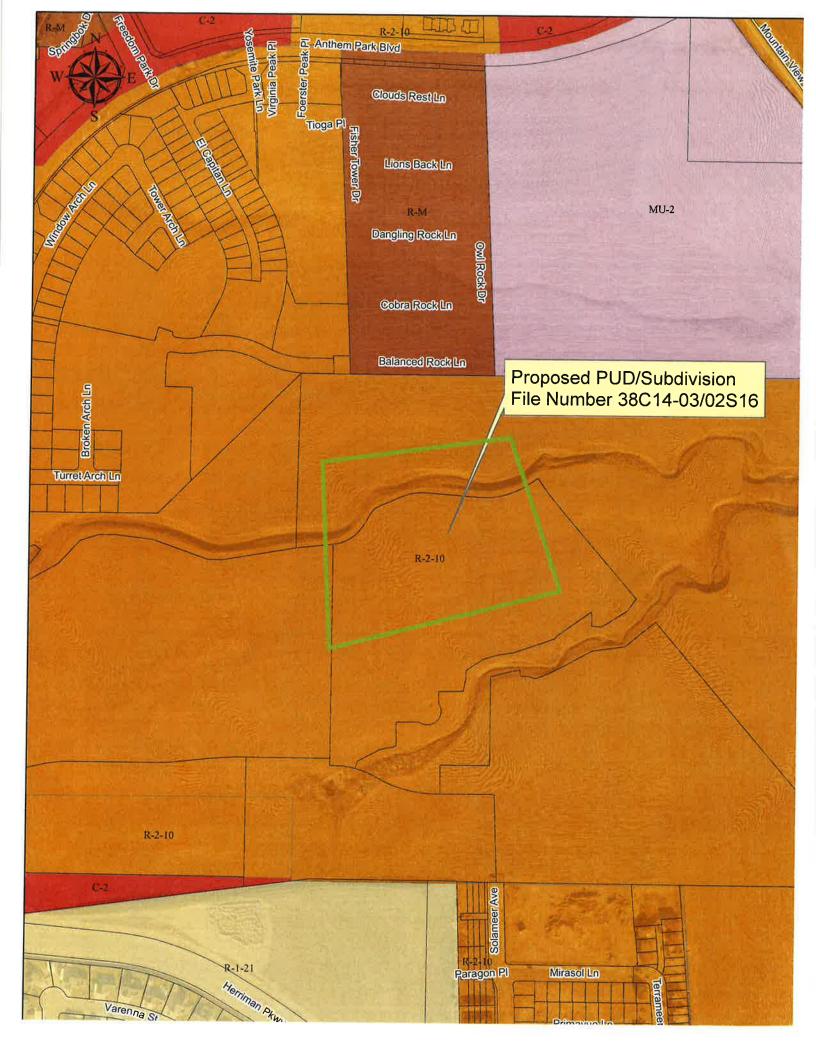
Subdivision Requirements:

- l. Meet with the Staff for review and final approval of the site plan.
- 2. Receive and agree to the recommendations from other agencies.

- 3. Install curb, gutter and sidewalk on all public streets.
- 4. Provide a CLOMR for the entire project. No property lines may be within the flood plain.
- 5. No property lines shall be within 20 feet of the top of bank of Copper Creek, as determined by the City Engineer.
- 6. The entry islands shall be maintained by the HOA. Work with engineering on an agreement for maintenance of the entry islands.
- 7. Provide a storm water analysis and detain to City standard. Detention may be off-site. Work with engineering on the overall detention of the project.
- 8. Provide a traffic study to the City engineer for review and approval.
- 9. Plat not to be recorded until a Development Agreement for Miller Crossing is approved by City Council.
- 10. Maximum of 30 units on one access per UFA.

PUD Requirements:

- 1. Provide an open space summary.
- 2. Fencing along the trail shall be 6 foot tan vinyl.
- 3. Install a 6 foot precast wall along Main Street. The design shall be reviewed and approved by the Planning Staff.
- 4. Dedicate and build an asphalt trail along Copper Creek. Provide at least one trail connection between the buildings to connect to the trail along Copper Creek. Trails should be constructed to meet City standard.
- 5. Setbacks from the public right of way shall be at least 15 feet. Setbacks between buildings shall be at least 10 feet.
- 6. All of the open space within the project will be maintained by the HOA.
- 7. Building elevations to be reviewed and approved by the Planning Commission, a minimum of 30% of the front exterior and any side or rear viewable from a street shall be brick or stone.
- 8. Maximum density in this pod of 11.2 du/acre.
- 9. Minimum of 245 parking spaces / 2.5 spaces per unit.







Architecture

Architecture Interior Design Landscape Architecture Land Planning Construction Management

CLAYTON HOMES MILLER CROSSING

PROJECT NO. ——
DATE: 05 OCT, 2015
REVISIONS:

SHEET TILE:
TOWNHOME

TOWNHOME MASTER-PLAN

MASTER-PL/

A 100









Address or location of site (No Post Office Box #) 5500 Was 1000 S
Size of Parcel 8,91 Bd #8 Willin (Mosping -
What is Requested (explain in detail)? Timple Proposed (explain in detail)?
If applicable, square footage of proposed building(s) or addition (all stories combined)
If the request is residential, how many and what type of units (apartment, condo, etc).
Property Owner's Name Ballet Ruby
Mailing Address P. D Box 211 West bridgen, 14- 84084
Applicant Claryon Homes. Inc
Mailing Address 1623 E Woodcrest De SLC, UL 84117
Telephone 301-277-9995 Cell Number 80-859-9995 E-mail johne clay ton homes who L. cor
Subject to Purchase or Lease: purchase or Present Owner of Property:
Yes I am the authorized agent or owner of the subject property:
Current Use of Subject Property Aq.
Proposed Development Name
For Herriman Use Only
Check Number Date of Submittal File Number 38C14-03
Filing Fee Receipt Number Accepted by

Phone: (801)446-5323 Email: planning@herriman.org



01/21/16		
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)		

Request for 02S16/38C14-03 - Meeting Date 1/21/2016

The applicant is requesting subdivision and final PUD approval for 100 townhome units.

Site

The parcel is located at approximately 5500 W 12100 S and contains 9.34 acres. This is Pod 8 on the approved PUD land use plan.

Zoning

The site is zoned R-2-10.

Background

The Miller Crossing PUD received approval in March of 2015. The approval was subject to several conditions. One of the conditions required each phase to come back to the Planning Commission for final approval.

<u>Issues</u>

Pod 8 is proposed at 10.7 units per acre. The approved pod is for 12 units per acre. The overall density approved in the Miller Crossing PUD is 6 units per acre.

The applicant has submitted building elevations for review and approval. The approved CCR's require a minimum of 30% of the front exterior and any side or rear viewable from a street shall be brick or stone.

The ordinance requires 2 parking spaces per unit. The proposed townhomes each have a 2 car garage. The total parking provided is 245 / 2.5 spaces per unit.

The Planning Commission should look at each phase of the PUD and attempt to incorporate the required open space in each phase. The open space is not specified on the site plan. The applicant will need to provide an open space summary for this pod.

Recommendation

Staff recommends approval of the subdivision and final PUD of 100 townhomes with the following:

Subdivision Requirements:

- 1. Meet with the Staff for review and final approval of the site plan.
- 2. Receive and agree to the recommendations from other agencies.

- 3. Install curb, gutter and sidewalk on all public streets.
- 4. Provide a CLOMR for the entire project. No property lines may be within the flood plain.
- 5. No property lines shall be within 20 feet of the top of bank of Copper Creek, as determined by the City Engineer.
- 6. The entry islands shall be maintained by the HOA. Work with engineering on an agreement for maintenance of the entry islands.
- 7. Provide a storm water analysis and detain to City standard. Detention may be off-site. Work with engineering on the overall detention of the project.
- 8. Provide a traffic study to the City engineer for review and approval.
- 9. Plat not to be recorded until a Development Agreement for Miller Crossing is approved by City Council.
- 10. Maximum of 30 units on one access per UFA.

PUD Requirements:

- 1. Provide an open space summary.
- 2. Fencing along the trail shall be 6 foot tan vinyl.
- 3. Install a 6 foot precast wall along Main Street. The design shall be reviewed and approved by the Planning Staff.
- 4. Dedicate and build an asphalt trail along Copper Creek. Provide at least one trail connection between the buildings to connect to the trail along Copper Creek. Trails should be constructed to meet City standard.
- 5. Setbacks from the public right of way shall be at least 15 feet. Setbacks between buildings shall be at least 10 feet.
- 6. All of the open space within the project will be maintained by the HOA.
- 7. Building elevations to be reviewed and approved by the Planning Commission, a minimum of 30% of the front exterior and any side or rear viewable from a street shall be brick or stone.
- 8. Maximum density in this pod of 11.2 du/acre.
- 9. Minimum of 245 parking spaces / 2.5 spaces per unit.















Date of Meeting: 01/21/16					
File #	01P16				
Applicant	Demie				
Address	13727 S Rocky Point Dr				
Request	Request for a Reasonable				
	Accomodations for up to 12 occupants				
	for a Residential Recovery Facility				

Request for 01P16 - Meeting date 01/21/2016

The applicant is requesting a reasonable accommodation for a residential recovery facility for up to 12 occupants. This is an amended and supplemental request to their original application.

Site

The parcel is located at 13727 S Rocky Point Drive.

Zoning

The site is zoned A-1.

Ordinance

A residential facility for persons with a disability is a permitted use in all zones. The ordinance states:

10-27-5: DEVELOPMENT STANDARDS:

The development standards set forth in this section shall apply to any residential facility for elderly persons or any residential facility for persons with a disability.

- A. Building, Safety And Health Regulations: The facility shall comply with building, safety and health regulations applicable to similar structures.
 - 1. Each facility shall be subject to the same development standards applicable to similar structures located in the same zoning district in which the facility is located.
 - 2. The minimum number of parking spaces required for a facility shall be the same as for similar structures located in the same zone in which the facility is located.
- B. Occupancy: Pursuant to the definition of "family" in section <u>10-2-1</u> of this title, not more than four (4) unrelated persons shall occupy a residential facility for elderly persons or any residential facility for persons with a disability established in a dwelling unit unless a reasonable accommodation for a greater number of occupants is granted.
- C. Prohibited Tenants: No facility shall be made available to an individual whose tenancy would:
 - 1. Constitute a direct threat to the health or safety of other individuals; or
 - 2. Result in substantial physical damage to the property of others.

- D. Operator Requirements: Prior to occupancy of any facility, the person or entity operating the facility shall:
 - 1. Obtain a city business license, if required under applicable provisions of this code;
 - 2. Provide to the community development director a copy of any license or certification required by the state department of health or department of human services; and
 - 3. Certify in a sworn statement that no person will reside or remain in the facility whose tenancy would:
 - a. Constitute a direct threat to the health or safety of other individuals; or
 - b. Result in substantial physical damage to the property of others.

Reasonable Accommodation

- C. Decision Of Planning Commission: The planning commission shall render a decision on each application for a reasonable accommodation within sixty (60) days. The decision shall be based on evidence of record demonstrating all of the following:
 - 1. The requested accommodation will not undermine the legitimate purposes of existing zoning regulations, notwithstanding the benefit that the accommodation would provide to a person with a disability.
 - 2. That, but for the accommodation, one or more persons with a disability will be denied an equal opportunity to enjoy housing of their choice.
 - 3. That equal results will be achieved as between the person with a disability requesting the accommodation and a nondisabled person.

It is up to the applicant to demonstrate how they meet the 3 criteria listed in the ordinance.

Recommendation

The Staff makes no recommendation. The Planning Commission decision should be based on the applicant's ability to meet the criteria listed above.

RENEW WELLNESS & RECOVERY ESTIMATED PRO FORMA - MONTHLY AVERAGES

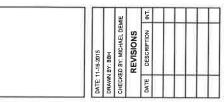
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Psychiatrist				Supervision/Therapy
	1000	2600	7800	Therapy/Groups
Office Manager		1000	3000	Medication Management
	4500			Billing/Payroll/Clerical
Billing Services		5280	15840	Outsourced Billing 11%
Banking Services	350			Credit Card Processing
Case Manager		2640	7920	Client Services
House Manger	2500			Maintenance/Schedule/Supplies
House Staff		10800	32400	Client Services
Business Office	1200			Web/Phone/Software/Internet
Website	250			SEO/Site Hosting
Accounting (CPA)	600			Tax Compliance/Distributions
Insurance	75			Pro liability/Bus Owners Policy
Marketing Manager	3700			Business Development
Marketing Meals	100			Business Development
Marketing Material	150			Business Development
Office Supplies	75			Paper/Etc.
Client Supplies		400	1200	Journal Books/Program Guide
Household items		1200	3600	Food/Personal Items
House Utilities	425			Gas/Elec/Water/Garbage
Facility Rent	5000			Mortgage
Training & Education		400	1200	CPR/Behavior Mgt/Food Permit
Advertising	350			Community Awareness
Business LCS	20			State/City Licensure
Transportation	500			Van/Gas/Insurance
Capital Improvements	2500			Monthly Loan Payment
Employee Benefits	3600			Health Insurance/PTO

	rixeu	4 Clients	12 Clients
Expense	\$32,895.00	\$ 24,320.00	\$ 72,960.00
Revenue Projections		\$ 60,000.00	\$180,000.00
Scholarship Bed**		\$(15,000.00)	\$ (30,000.00)
Total Net Revenue		\$(12,215,00)	\$ 44 145 00

^{*}This is an estimate of the average monthly expenses and revenues based upon research of similar facilities in the state and actual expenses incurred to date where those numbers are available.

^{**}Renew will reserve at least one scholarship bed to accommodate an individual who cannot afford the cost of treatment.

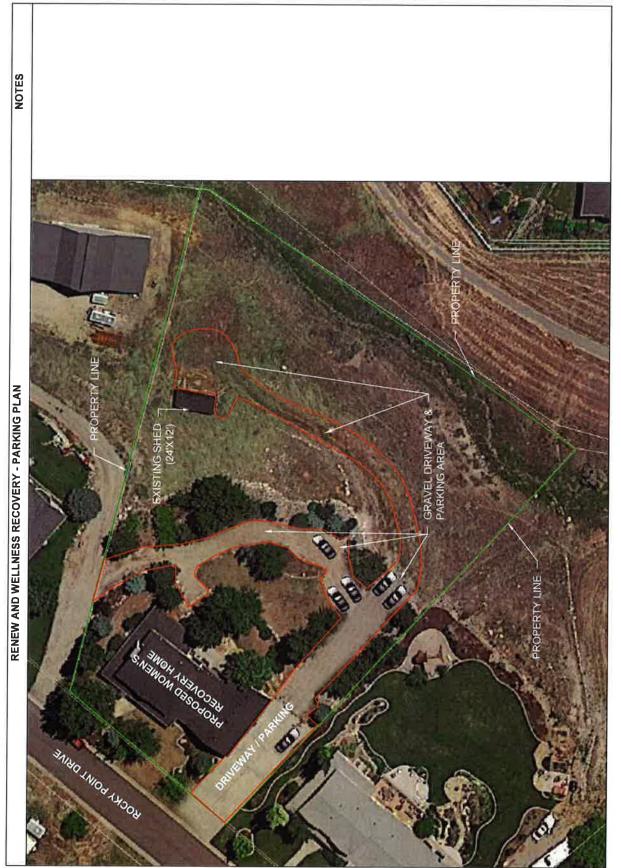




RENEWAY, UT BADSE
13727 SOUTH ROCKY POINT DRIVE
13727 SOUTH ROCKY POINT DRIVE



DRAWING TITLE: PARKING LAYOUT





Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment



Editorial

Five-Year Recovery: A New Standard for Assessing Effectiveness of Substance Use Disorder Treatment*



1. Introduction: why a new definition of effectiveness and why now

The treatment of addiction to alcohol, illicit and/or pharmaceutical drugs has been segregated from the rest of health care, conceptually (debate on whether addiction is an illness), organizationally (separate government agencies provide most licensing and regulatory control), and most importantly — financially. Addiction treatment has been funded predominantly through federal block grant dollars and many other state and federal mechanisms — with limited funding through federal or private health care insurance.

Not surprisingly, the nature of contemporary addiction treatment is quite different from the treatment of most other serious and wide-spread chronic illnesses. Addiction care is provided by "treatment programs" offering standard sets of services (predominantly counseling) in acute care-oriented, time-limited settings. In parallel, there has also been expansion of medication-assisted treatment (MAT) using methadone, buprenorphine and naltrexone for opioid dependent patients. This care has also been delivered by specialized programs or practices that are largely segregated from the rest of healthcare.

This segregation of addiction treatment is changing with implementation of multiple health care reforms within the federal, state and private sectors. Most prominently and far-reaching are the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (Parity Act) (Barry & Huskamp, 2011; Dentzer, 2011). The historic provisions of these acts require health insurers to cover, and health care organizations to provide, prevention, screening, brief interventions and treatment for the full spectrum of substance use disorders (SUDs) -"harmful use" through "addiction." Together these two pieces of legislation require that care for SUDs has the same type, duration, range of services and patient financial burden as the care currently available to patients with comparably serious physical illnesses. The illnesses considered to be "comparable" to addiction are acquired, chronic illnesses such as hypertension and particularly Type 2 diabetes (McLellan et al., 2000). Importantly, this legislation has mandated care delivery within mainstream health care settings including primary care.

These are not simply mechanistic changes in financing and regulations. These mandates signal remarkable changes in how SUDs are to be conceptualized and managed as well as how they are evaluated for effectiveness and value. It is likely that within the next decade SUDs will be treated like other serious, chronic illnesses, increasingly by the same multidisciplinary treatment teams now practicing general health

care, and using the same continuing management and monitoring approaches to achieve the goals of long term "disease control" and "patient self-management." In addition, the currently separated and distinct addiction treatment programs may serve as part of an overall approach to care management, much as cardiology or endocrinology serves as specialty services in the care of patients with coronary artery disease or diabetes. What is missing in addiction care is the long-term continuity and monitoring generally provided in primary care for other chronic diseases.

There is much to be optimistic about in the prospects for integration of addiction care into mainstream chronic care management. Buprenorphine treatment already shows some success as a model for integrating addiction services into general medicine. This has increased access to care for previously untreated opioid addicted patients. The majority of wavered physicians who prescribe buprenorphine are not practicing in traditional specialty addiction or opioid treatment programs. Yet, as this integration proceeds to include additional services, there are important conceptual and methodological issues on which the addiction field must reach consensus. For example, in other areas of chronic illness management there is consensus on when treatment is necessary (and when services will be paid for), almost always based upon one or more objective biological markers signifying disease status (e.g., blood pressure readings, HgA1c results, weight, etc.). As treatment progresses, these markers are repeatedly monitored as part of the ongoing evaluation of the effectiveness of the care delivered to that point; and used to guide modifications to care (e.g., reduce or increase medication dose, add or reduce supportive services, etc.). When the biological markers monitored reach sustained normal levels and there is return to function in the activities of daily life, the illness is considered to be "under control" and at that point the number, frequency and intensity of care supports and monitoring are reduced (in conjunction with increases in patient and family education and training). This does not mean that the patient is not provided any care or monitoring, nor does it mean that no action is required by the patient who has achieved this status. Instead, it means that the patient is doing the things necessary to maintain this positive health status. The most favorable health outcomes that can be expected are "disease control" (reduction in symptoms to normal levels concomitant with good functional status) under "patient self-management." For instance typical care of patients with Type 2 diabetes includes routine self-management by patient and quarterly office visits to a physician to perform a physical exam, to review tests (e.g. hemoglobin A1C levels and blood glucose), and to provide counseling. Coordination of care with other specialties (e.g. ophthalmology) if needed is also conducted. Such a model for monitoring and coordination with specialty services could be used in addiction care management.

Compared to other chronic illness management strategies addiction treatment shares the ultimate objective of patient self-management of

[⇒] Disclaimers: The findings and conclusions of this article are those of the authors and do not necessarily reflect the views of the National Institute on Drug Abuse, the National Institutes of Health or the U.S. Department of Health and Human Services.

their illness; but addiction treatment has fewer medications and more social and behavioral services to offer patients during the course of treatment. Furthermore, the very limited training in addictions in medical professions and the resulting stigma among medical professionals represent significant barriers to full integration into mainstream medical care. Yet, the addiction field has one solid biological marker signifying the presence of a primary symptom of the "disease state": substance use, detectable through biological specimen testing (e.g., urine, oral fluids, hair, sweat, etc.). Thus, a central conceptual question for the addiction field as it joins the rest of chronic illness management is what is the acceptability of drug testing during treatment to monitor treatment efficacy; and, in combination with other measures of general health and function, as a long-term measure of treatment effectiveness. This paper advocates a consensus method of measuring and managing addiction services; and for judging effectiveness and value of addiction services based on the goal of five year recovery.

2. Disease control in addiction treatment: what, why and how

Three factors have the potential to reshape the management and the measurement of the effectiveness of SUD treatment. The first is the severity, complexity and chronicity of SUDs among persons in treatment for these conditions. The prevalence of substance use problems in the general population is variable, but chronic, severe substance use as well as significant medical comorbidity is not common. In contrast, marked severity, chronicity and complexity are common among those people who meet diagnostic criteria for addiction - and virtually universal among the still smaller proportion of addicted individuals referred for treatment. People with SUDs rarely acknowledge that they have a disorder and usually do not want treatment, typically rejecting referral. Even among those who enter specialty treatment, many drop out before completion (Brorson et al., 2013; Dakof et al., 2001; McHugh et al., 2013; Samuel et al., 2011). Not surprisingly, relapse to substance use following treatment discharge is a common outcome among the severely affected population. Advances in brain imaging and genetic studies have provided a biological understanding of this typical treatment trajectory. There are now well-documented progressive, drug-related changes in brain circuits associated with reward, motivation, and cognition associated with virtually every substance with addictive liability (Koob & Volkow, 2010).

The second important factor reshaping clinical management in this field is the recognition that SUDs are seldom the result of the use of a single drug. Most people with SUDs have problems with many substances including alcohol and tobacco. Combined with increasing scientific evidence of long-lasting changes in motivation and reward salience that accompany addictions, it is understandable that most contemporary strategies for treatment-seeking patients who generally have severe substance use disorders do not attempt to engender "controlled substance use" advocating instead for complete abstinence from alcohol and other potentially addictive substances (with the exception that tobacco abstinence has been inconsistently encouraged).

The third factor reshaping addiction care is the rapid organizational and management changes generally occurring in health care — particularly health care for serious chronic illnesses such as asthma and diabetes (Coleman et al., 2009). Contemporary chronic care is now proactive and individualized, relying upon regular monitoring of patient symptoms, function and risk factors combined with sophisticated and individualized combinations of medications, social services and patient/family education to detect incipient relapse and intervene rapidly to prevent escalation of illness, morbidity and health costs. In this new model of health care, chronic conditions are carefully managed by monitoring patients pro-actively over many years to prevent and intervene early with relapses.

These three changes provide a contextual framework for a fresh look at clinical management and measuring the effectiveness within addiction treatment. It is important here, to note that we are specifically

referring not to the broad group of individuals with risky substance use or mild/moderate substance use disorder, but instead to those with severe substance use disorder referred for treatment (i.e. generally those with complicated multi-substance use issues that are so typical of treatment samples). Key to this context is a change in clinical focus away from reactive, time-limited episodes of care administered in isolated silos. The move now is toward long-term management of all substance use, including alcohol and tobacco. Further, many treatment providers believe that the primary route to achieving the shared goals of improved functioning and health is through sustained abstinence from the use of all addictive substances because any use of substances that produce intense brain reward is likely to trigger a relapse and thereby risk significant morbidity and mortality. This goal of abstinence is not universally accepted by professionals in the treatment of addiction but it is well-established for tobacco, where even the use of a single cigarette is considered to threaten long-term abstinence.

This reorientation brings new meaning and rationale for an old and well-established target in the treatment of addictions, "recovery." While the definition of recovery has been controversial, it has been defined as "a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" (Betty Ford Institute Consensus Panel, 2007), "a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction" (American Society of Addiction Medicine, 1982) and "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration, 2012). Consider the logic of this conclusion. Science and clinical experience show that addiction is best understood as a chronic, complex illness typically manifest by substance-related, perhaps genetically-mediated changes in brain structure and function leading to impaired ability to control substance use. What makes an illness "chronic" is that it cannot be cured. Instead it can be medically controlled and managed toward the ultimate goal of patient self-management. Further, in our view, patients using medications in their treatment, including methadone, buprenorphine and naltrexone should be considered to be in recovery if they are using the medicines as prescribed and abstaining from using alcohol and other addictive drugs. Recovery can be supported by these medications, which are intended to support the patient's normalizing their social-emotional functioning and minimizing intoxication.

With this reorientation comes the availability of a clear, objective, biological measure of "disease control" — drug screening of urine or other biological matrices (hair, blood, oral fluid, and sweat). Drug screening measures have many of the same clinical advantages as comparable measures of disease control now used in the monitoring and management of other chronic illnesses — e.g. blood pressure, weight, HgA1c, etc. These measures can be easily and inexpensively collected and interpreted. Recurrent biological screening for alcohol and other drugs within clinical settings serves the joint purposes of determining effectiveness of care delivered to that point; and guidance for how to adjust ongoing treatment that has not yet achieved the goal of complete and sustained abstinence.

3. A model of "chronic disease management" that consistently produces positive long-term outcomes for SUDs

To continue the argument that addiction can be conceived and managed like the other chronic illnesses, the proposed reorientation suggests an ambitious, but achievable, longer-term outcome goal for the treatment of addiction — Five Year Recovery (Institute for Behavior and Health, Inc, 2014a). Based on a new paradigm for care management of SUDs, this model has demonstrated that long-term abstinence and recovery can be the expected outcome of addiction care, particularly for patients with severe substance use disorders.

During the past four decades the U.S. Physician Health Programs (PHPs) have developed a unique state-based system of care

management for addictions (and other behavioral disorders) with the goal of producing the best long-term outcomes, that is, "recovery." These programs, commonly working in cooperation with state licensing boards, do not provide any treatment or monitoring themselves. Instead, they manage the care of participating physicians for five years or longer. Physicians referred to their state PHP begin with a detailed, formal medical evaluation. Those who are diagnosed with substance use disorders are offered a contract in which the PHP provides a safe harbor for the physicians by verifying their abstinence from any use of alcohol or other drugs and their continued compliance with the recommendations of the PHP (DuPont et al., 2009). The diagnosed physicians are then referred to treatment programs that have demonstrated to the PHPs the excellence of their work (Talbott & Wright, 1987). Physicians typically enter either 30 to 90 days of residential treatment or three months or more of intensive outpatient treatment. Comorbid conditions and other problems are identified and addressed.

Physicians are monitored for any alcohol or drug use through frequent random drug and alcohol testing. Each day they must check to see if they are required to be tested that day. Typically the initial random testing frequency is once or twice a week. After long demonstration of abstinence, the frequency is gradually reduced to once a month. Any positive test or any missed test is considered a serious violation of the program rules and typically leads to the physician being taken out of practice for an extensive reevaluation. The physicians are encouraged to participate in community support groups, usually Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and generally participate in 12-Step meetings specifically limited to health care professionals (often called "Caduceus meetings"). The long-term recovery outcomes from this care management are remarkable (Skipper et al., 2009). For example, a study of 16 PHPs showed that over the course of five years of monitoring, 78% of physicians never had a single positive test for alcohol or drug use, and of those who tested positive, two-thirds only had a single positive test result (McLellan et al., 2008).

Evidence from two criminal justice programs, HOPE Probation and South Dakota's 24/7 Sobriety Project, with comparable intensive monitoring procedures, suggests that similar rates of abstinence and improved quality of life can be achieved in criminal offender populations with substance use problems (DuPont & Humphreys, 2011). Caron Treatment Centers has developed a program based on the care management of PHPs, called My First Year of Recovery. Similar experiences with dramatically different populations suggest that this model of care management can be widely applied, at least when there is significant leverage to make monitoring failures consequential (Institute for Behavior and Health, Inc, 2014b).

We recognize that health care generally lacks the leverage that characterizes both the PHP model and the programs in the criminal justice system. Addicted physicians can lose their licenses for continued drug and alcohol use and offenders under supervision in the criminal justice system can be jailed for continued alcohol or other drug use. We cite these examples because of the extended duration of their random monitoring and care management which deserves consideration for implementation in health care settings. Nevertheless, a key issue differentiates addiction from these other chronic conditions: typically negative responses to ongoing drug use. Unlike diabetes or hypertension care, in addiction care, there can be severe social (including legal) consequences for positive urine drug screens or missed appointments. This is a complexity with which all clinicians and clinical researchers grapple. Of course, an approach to consider which mimics other chronic diseases is to use continued drug use (or other behavioral manifestations of potential relapse) as reasons to change and possibly intensify treatment until improvement is seen. The goal is clinical improvement, not punishment, which is the same goal that characterizes the PHP programs and the two criminal justice programs cited here, HOPE Probation and 24/7 Sobriety.

One key way to take such a long-term, recursive approach is within primary care and health care systems themselves. Unlike isolated and often time-limited specialty treatment programs, the overall health care system has long-term (sometimes even lifetime) relations with patients and families permitting even longer-term monitoring and management than these programs provide. Within health care, the consequences of continued alcohol and other drug use should not lead to punitive intervention but to new or intensified care, just as in the model used for promoting healthy behavior for other chronic disorders such as diabetes and coronary artery disease. Health care providers may manage the process using outside organizations providing the specialty care that is required. This model of long-sustained care management is available to medical care organizations, permitting them to take advantage of the expertise of community resources while maintaining continuing responsibility for the care of these patients within the general health care (or primary care) setting.

4. The standard of five-year recovery

The precise need for "five years" is modeled not only after the PHP standard but also after the well-known long-term cancer survival model. In cancer, this model has come under criticism because some cancers have a much more rapid recurrence and a shorter duration of remission would indicate "cure" while for other cancers, "cure" may not be certain until even more years have passed. Despite these shortcomings, the concept of extended abstinence predicting markedly improved outcomes is clear. The work of Dennis, Foss, and Scott (2007) on the long-term trajectories of persons entering drug treatment suggests approximately three years of abstinence as indicating high likelihood of a stable recovery. Vaillant (2012), in his landmark study of alcoholism, supports the use of five years of abstinence as a standard indicating that the risk of relapse is no longer greater than that of the general population. While the precise duration of abstinence needed to define a stable recovery isn't fully established, our goal is to move toward a system of care for SUDs that encourages long-term recovery.

Adoption of five-year recovery as a standard treatment outcome measure does not replace other measures of effectiveness, including in-treatment assessments and functional outcomes (e.g. employment), but rather it adds to those measures and should support their achievement. It ensures that a standard measure of treatment success is long-term recovery. This encourages addiction treatment programs and clinicians to work to make recovery, not relapse, the expected outcome of treatment (Institute for Behavior and Health, Inc, 2014b).

In this regard, we have to question the all-too-common research paradigm to evaluate the effectiveness of a new medication or behavioral therapy - typically a 12-week randomized clinical trial; usually lacking any continuing care; and often evaluated 6 or 12 months "posttreatment." Consistent with disease management models currently used in other illnesses, these typical trials do evaluate "during treatment" reductions in symptoms (substance use) and function (social and health) thereby providing early indicators of benefit. They can be considered interim outcomes for acute episodes. However, unlike the management of other illnesses; and unlike the management model used by PHPs, very few of these trials provide any form of continuing care that is embedded into a robust long-term care management system. Also, while abstinence and symptom reduction may be the most likely pathway to recovery, further thinking about how best to measure long-term functional improvements will be needed to improve this long-term approach to patient outcomes.

Using sustained five-year abstinence and recovery as a primary measure of outcomes can reshape both treatment outcome research as well as clinical practice. It can increase the quality of treatment, spawn a new generation of monitoring and care management and deliver more consistently the outcome widely sought but seldom achieved: a sustained healthy lifestyle. Having a five-year recovery standard for all systems of care will provide useful information for patients, families and funding sources. It will also create a goal toward which programs strive.

A commitment to routine, long-term monitoring of patient behavior and compliance to improve five-year outcomes as part of patientcentered medical care with long-term monitoring and frequent assessment holds great promise for the management of SUDs. With this model, clinicians are encouraged to monitor patients with SUDs routinely to maintain recovery. The successful management of SUDs includes conducting random tests (sometimes frequently, especially early in care) for the use of alcohol and other drugs to monitor compliance, similar to the sustained monitoring for diabetes and hypertension. This model of integrated long-term monitoring and care management is now being more widely adopted throughout medicine. It requires incorporating many elements of the PHP model into routine health care for every patient suffering from a substance use disorder. Yet, a key challenge in caring for patients with addictions will be to assure that the response to a test that indicates substance use is proactive and supportive. The goal is to encourage behavior change through a positive treatment environment, not to drive patients further into the shadows. Thus, implementing these new approaches will require careful assessment.

Clinicians need to recognize their important role in medically managing addictions and that they also need to identify long-term recovery as the ultimate objective of their care. With further research, it may turn out that abstinence is not the only route to such healthy outcomes, especially for those with milder or sub-threshold substance use disorders, but at the present time, abstinence is the most supported approach to achieving meaningful recovery for treatment-seeking patients (National Institute on Drug Abuse, 2015). In the model we are proposing, this means articulating the abstinence objective to patients and their families and then monitoring for its achievement as a means of supporting recovery. In addition, the five-year recovery standard for assessing treatment outcomes encourages treatment programs to look beyond the time of formal episodes of care of their patients. Acceptance of the five-year recovery rate permits all addiction treatment programs to compete on a level playing field.

5. Conclusions

The discussion of strategies for monitoring and measuring treatment response five years after entering treatment is built on the evaluations that have been conducted on the physician health programs and the initial effort of the committee convened by the Betty Ford Institute to define "recovery" including an important review of the instruments now available to assess recovery in individual patients (Betty Ford Institute Consensus Panel, 2007). Today there is an obvious need to create new instruments and cost-effective, practical strategies to assess interim and long-term treatment outcomes for SUDs.

Rather than lay out the specifics of the proposed strategies we encourage a fresh look at treatment evaluation using the standard of five-year recovery. Our focus is on how this new goal can shift the way treatment is assessed to create incentives for substantially improving treatment outcomes. Our goal is to make recovery, not relapse, the expected outcome of substance use disorder treatment.

The confluence of forces in medicine today encourages a new look at evaluating the effectiveness of treatment for SUDs, expanding the focus from one drug to all addictive drugs, including alcohol and tobacco, as well as both during and after treatment. The five-year recovery standard offers a model that can be applied to various populations by identifying an intake sample and following them for five years following admission to treatment.

The identification of five-year recovery rates for treatment programs will give a level playing field for comparing a wide range of treatment programs and it will encourage all treatment programs to focus their attention on long-term patient outcomes. This will in turn facilitate innovation in addiction treatment and reward programs and treatment modalities that are better able to achieve long-term recovery with resulting functional and health improvements.

Finally, there are significant implications of using five-year recovery as the outcome for research. We see five-year recovery as a useful conceptual standard to inspire both practice and research. Yet, few "evidence-based practices" have been tested against this standard; most are primarily examined for their short-term impact. These current studies can provide key treatment resources that can be part of the care management envisioned using the five-year outcomes. How evidence based treatments can be incorporated into a recursive model of continuing care is just beginning to be studied (Dennis & Scott, 2012). Even when it comes to addiction medications, there is controversy about whether these are best for early stabilization or for long-term maintenance care. Further, the very nature of most research funding with a maximum of five years of support, makes a five-year outcome a difficult goal for a single study. New research methods that take advantage of electronic health records for comparative effectiveness research present a possible solution. Recognizing these limitations, we encourage the research community to develop new approaches to study these essential long-term models of clinical and health outcomes.

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Robert L. DuPont, M.D.
Institute for Behavior and Health, Inc., 6191 Executive Blvd
Rockville, MD 20852
E-mail address: bobdupont@aol.com
Tel.: + 1 301 231 9010

Wilson M. Compton, M.D., M.P.E.
National Institute on Drug Abuse, 6001 Executive Blvd
Rockville, Maryland 20852
Corresponding author. Tel.: +1 301 443 6480
E-mail address: wcompton@nida.nih.gov

A. Thomas McLellan, Ph.D.
Treatment Research Institute, 600 Public Ledger Building
150 S. Independence Mall West, Philadelphia, PA 19106
E-mail address: TMcLellan@tresearch.org
Tel.: +1 215 399 0980.

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Multilevel modeling was used to assess the program characteristics associated with treatment retention among 637 women in 16 residential drug treatment programs in the Drug Abuse Treatment Outcome Study. Women who were pregnant or had dependent children had higher rates of retention in programs in which there were higher percentages of other such women. Longer retention was associated with higher rates of posttreatment abstinence. Bivariate analyses showed that programs with higher proportions of pregnant and parenting women provided more services related to women's needs. The findings support the provision of specialized services and programs for women in order to improve outcomes of drug abuse treatment.

PROGRAM VARIATION IN TREATMENT OUTCOMES AMONG WOMEN IN RESIDENTIAL DRUG TREATMENT

CHRISTINE E. GRELLA
VANDANA JOSHI
YIH-ING HSER
University of California, Los Angeles

In the past two decades, there has been a growing understanding that women's alcohol and drug use differs from men's in several ways, including the initiation of use, progression to dependence, and psychosocial correlates of use (Reed 1987; Grella and Joshi 1999). These differences also influence the ability of women to access and participate in drug treatment. In addition, women who are pregnant or who have dependent children often are hindered from entering or completing drug treatment because of the absence of child

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care or special services for women, especially among programs for both men and women (Haller et al. 1997; Lewis et al. 1996; Prendergast, Wellisch, and Falkin 1995). Even if drug treatment programs accept pregnant women for treatment, they often fail to address their specific service needs. One survey of approximately 300 drug treatment programs in five cities in 1992 found that although the majority accepted pregnant women for treatment, few programs made referrals for prenatal care (Breitbart, Chavkin, and Wise 1994).

Drug treatment for women needs to take into consideration their special needs related to pregnancy and child rearing. Pregnant substance-abusing women typically have limited economic resources and weak social support networks; suffer from depression, anxiety, and low self-esteem; have feelings of shame and guilt; and often have histories of childhood trauma, parental substance abuse, and abusive relationships (Davis 1990; Eliason and Skinstad 1995; Grella 1996; Haller et al. 1993; Howell and Chasnoff 1999; Marcenko and Spence 1995). Pregnant women are often in need of basic health and obstetrical services as well as mental health treatment upon entering drug treatment (Jessup and Green 1987; Morris and Schinke 1990; Wagner and Menke 1992). Moreover, mothers who abuse alcohol or other drugs often are in need of parenting assistance, and their participation in drug treatment may influence their ability to retain or regain custody of their children.

Public concern about the consequences of maternal substance abuse has focused the attention of policy makers on developing interventions to reduce substance use among women who are pregnant and/or parenting (Schmidt and Weisner 1995). One such response has been an increase in funding for special services and programs designed specifically for women with substance abuse problems (Breitbart, Chavkin, and Wise 1994). In 1984, the federal government amended block grant legislation to require each state to set aside 5% of its block grant allocation for new or expanded alcohol and drug abuse services for women. States were encouraged to spend set-aside funds to develop women-only treatment units, programs offering special ancillary services for women, and services for pregnant women. By 1988, amid public concern over drug-exposed infants and the national "war on drugs," Congress doubled the "women's set-aside." In addition, in the late 1980s and early 1990s, Congress enacted legislation that funded demonstration grants for model programs for drug-using pregnant and postpartum women (Nunes-Dinis 1993). Yet, recent evidence indicates that funding for specialized services and programs for women and the priority on treatment for pregnant and parenting women may be reversed by shifts in the control over funding from federal to state and local entities and from cost containment efforts (Chavkin and Breitbart 1997; Chavkin et al. 1998).

Despite these changes in policy and funding, research on specialized drug treatment services or programs for women has shown promising results (Stevens and Arbiter 1995). Several studies have demonstrated that treatment outcomes are improved by having live-in accommodations for children in residential treatment programs (Hughes et al. 1995; Wobie et al. 1997); by providing outpatient services, particularly family therapy (Zlotnick et al. 1996); and by providing supportive services, such as child care, parenting classes, and vocational training (Howell, Heiser, and Harrington 1999; Strantz and Welch 1995). Recent studies conducted in Los Angeles County showed that women-only drug treatment programs offered a wider range of services to address women's needs as compared with mixed-gender programs (Grella et al. 1999) and that women treated in women-only residential drug treatment programs were twice as likely to complete treatment as were women in mixed-gender programs (Grella 1999). However, specialized drug treatment programs for women, including pregnant women, are by no means universal, and most women receive drug treatment in mixed-gender programs (Grella and Perry 1996). Consequently, more research is needed to determine the characteristics of typical drug treatment programs, such as the types of services provided, that are associated with improved treatment outcomes for women.

This study examines the variability in treatment outcomes for women in residential drug treatment programs. Data were obtained from the Drug Abuse Treatment Outcome Study (DATOS), a national multisite prospective study of treatment effectiveness (Fletcher, Tims, and Brown 1997). This study included data collected on client characteristics and the characteristics of programs in which these clients were treated. Comprehensive information on programs was collected from program directors and was linked to the clients' individual-level data. The availability of these multilevel data enabled us to explore by statistical means the unique contribution of program characteristics associated with the variation in treatment outcomes (i.e., retention and posttreatment abstinence), after controlling for client-level characteristics.

METHODS

DATOS STUDY DESIGN AND DATA COLLECTION

The DATOS study sample consisted of clients who were admitted into 96 drug treatment programs across four types of treatment modalities in 11 cities

within the United States from 1991 to 1993 (see Flynn et al. 1997 for a description of the DATOS methodology). The present study focused on women clients in 16 long-term residential (LTR) programs that participated in DATOS. The other program modalities were not included, since we believed that program factors would be more salient and influential on treatment outcomes for clients in residential, as opposed to nonresidential, programs. Programs selected for study participation were relatively stable, well-established programs operating within community-based settings. Clients admitted consecutively to the participating programs were recruited into the study. Face-to-face interviews were conducted at intake into treatment, during treatment, and at follow-up. The intake assessment consisted of two 90-minute interviews: Intake 1 was administered at admission to treatment or shortly thereafter, and Intake 2 was completed after about 7 days of treatment. Intake 1 primarily obtained baseline data on background characteristics; Intake 2 provided information for clinical assessment.

The follow-up assessment was conducted approximately 1 year after discharge from the DATOS treatment with a subsample of the original intake sample. The follow-up interview lasted approximately 90 minutes, and subjects were paid \$15.00 for their participation. The follow-up sample was selected using a stratified design. The sample was weighted to include clients who stayed in treatment at least 3 months, and programs with fewer than 20 clients were omitted from the sampling frame to allow for analysis of program effects (Flynn et al. 1997). Of the 1,198 clients from 20 LTR programs selected to receive follow-up interviews, 676 (56.4%) were interviewed; 155 (12.9%) were eliminated because they were incarcerated or hospitalized in facilities that would not permit interviewer access, were incapacitated, or had moved outside the area; 13 (1.1%) had died; 18 (1.5%) refused to be interviewed; and 336 (28.1%) were not located. A comparison on key characteristics (e.g., age, gender, ethnicity, marital status, prior treatment history, pretreatment use of cocaine and heroin, and psychiatric status) showed no statistically significant differences between interviewed and noninterviewed clients. However, the follow-up sample was biased toward clients who remained in treatment longer, as a consequence of the sampling design.

In addition, data were collected from a mail survey of program administrators on the characteristics of their programs, such as services provided onsite and through referral, admission or exclusion criteria, and relationships with other service providers (Etheridge et al. 1997). Administrators or senior counselors from 19 LTR programs completed the program surveys. Three programs were dropped from the present analyses because they did not include any women.

SUBJECTS

Among the subjects (N = 2,774) admitted into LTR in the intake sample, 33.2% were women. This study used a sample of 637 women from 16 LTR programs in the analysis of treatment retention. Characteristics of this sample are shown in Table 1. More than half (54%) of the women were White, 30% were African American, 12% were Hispanic, and the remainder (4%) were either Asian or Other. More than half (55%) were 30 years of age or younger. Approximately half (49%) had less than a high school degree. Nearly two fifths (38%) had ever been married, and 27% were currently married. Three fourths (75%) had children younger than age 18, and 7% were currently pregnant. Nearly half of the women with children (48%) said that their participation in drug treatment could affect their ability to retain or regain custody of their children, and 18% felt that their drug problem could cause them to lose custody of their children. One half of the women reported that they lived with parents or other family members prior to entering treatment; 29% lived with a spouse, with or without children; 8% lived with children only; 5% lived alone, and 9% had other living arrangements (e.g., jail or prison). In the year prior to entering treatment, about one third (34%) had been employed in either a part-time or full-time job, and close to half (48%) had received some form of public assistance income. At the time of treatment entry, 59% were under legal supervision, including probation, parole, or case pending.

A majority of the women (87%) met DSM-III-R (American Psychiatric Association 1987) criteria for dependence on cocaine, and 74% had used cocaine at least weekly in the year prior to admission. In addition, 22% were dependent on heroin and 47% on alcohol. The mean age of first weekly use of any drug was 22.8 (SD=6.6). Approximately 39% met criteria for antisocial personality disorder, and 15% had major depressive disorder in their lifetime. Approximately two thirds (65%) had prior drug treatment. About one fifth (21%) were self-referred to the DATOS treatment episode, and about one third were referred from the criminal justice system, one third from their families, and the remaining 10% from other sources (e.g., medical, employment, social services). The majority of the sample (71%) stated that entering drug treatment was their own, as opposed to someone else's, idea.

VARIABLES

Variables were chosen for the analysis to test the hypothesis that women treated in residential drug treatment programs that offer more specialized services for them have better treatment outcomes, controlling for relevant client characteristics. The time frame for the intake and follow-up assessments

TABLE 1: Sample Description (in percentages; N = 637)

Ethnicity	
White	53.7
African American	30.1
Hispanic	11.9
Other	4.2
Age	
18-25	22.8
26-30	31.8
31-35	26.8
36 and older	18.7
High school degree	50.7
Ever married	37.8
Employed (either part-time or full-time)	34.3
Received supplemental security income or Aid to Families	04.0
With Dependent Children income	47.5
Under criminal justice supervision	59.2
Currently pregnant	7.1
Has children younger than age 18	75.0
Of those with children	75.0
Concerned about losing custody	17.9
Drug treatment will affect custody	48.2
Has prior drug treatment	64.5
Living arrangement	04.5
Spouse/children	28.7
Child only	7.6
Any family combination/other	49.9
Alone	49.9
Institution	9.0
Used cocaine at least weekly ^a	73.7
Meets DSM-III-R criteria for	73.7
Cocaine dependence	86.8
Heroin dependence	21.7
Alcohol dependence	46.8
Antisocial personality disorder	46.8 39.4
Major depressive disorder	
General anxiety disorder	14.6
	5.3
Referral source to Drug Abuse Treatment Outcome Study treatment Self	04.4
	21.1
Criminal justice system Family	35.5
•	33.4
Other (e.g., employer, medical services, social services)	10.0

a. In 12 months prior to admission.

referred to the 12 months preceding admission and the time of follow-up, respectively. The construction of variables used in this analysis is

summarized below. All dichotomous variables were coded with yes = 1 and no = 0, unless specified.

Client characteristics. Several client characteristics that were assessed at treatment intake were entered into the models as control variables. These included age (continuous measure), ethnicity, educational status (high school degree or higher = 1, less than high school degree = 0), and marital status (ever married = 1, not married = 0). Employment status referred to either part-time or full-time work in the 12 months prior to admission and follow-up (employed = 1, unemployed = 0). Dependence on cocaine was based on the DSM-III-R (American Psychiatric Association 1987) criteria for lifetime dependence. Separate dichotomous variables indicated whether patients had ever received any kind of treatment for a drug problem prior to entering DATOS and whether they were under criminal justice system supervision at the time of treatment admission. A Reference Group Scale, with a Cronbach's alpha of .83 for this sample, was used to measure the extent of negative influence from family or close friends at intake into treatment. It consisted of seven items regarding how many of the individual's family members or friends had used illicit drugs (other than cocaine), used cocaine, drank alcohol heavily, been arrested, entered jail/prison, entered treatment (reverse coded), or quit using drugs (reverse coded) in the past 12 months, with 0 = none, 1 = few, and 2 = many. A higher score represents a more negative influence.

Program characteristics. Programs were characterized by data collected from the program administrator survey. Separate dichotomous variables indicated whether the program had as a priority for admission pregnant women and whether programs provided special services for pregnant women. In addition, administrators were asked whether their programs provided any of the following specific services: prenatal care, postpartum care, pediatric/well-baby care, transportation, medical services, educational services, family services, vocational services, psychological services, financial services, and legal services. Administrators were also asked about the quality of their program's relationships with other service providers (i.e., social service providers, family service providers, and community mental health centers); their responses were dichotomized with 1 = good or excellent, 0 = fair or poor.

Client variables aggregated at the program level. Based on the client intake data, the percentage of women in each program who were pregnant while in treatment or who had children less than 18 years of age was calculated (range = 54.4%-100%, median = 76%). Programs were also characterized by the percentage of women clients who reported at follow-up that they

had received certain services while in treatment and their evaluation of program services. These variables included the percentage of women who said they had a good relationship with their counselors, received mental health services while in treatment, followed program instructions, and received an aftercare plan prior to discharge from treatment.

Treatment outcomes. Treatment retention was defined as the number of days between DATOS treatment admission and discharge. Posttreatment abstinence referred to use of any drugs during the 12-month follow-up period.

ANALYTIC APPROACH

To understand client and program factors that predicted treatment outcomes, we conducted multilevel analyses, specifically hierarchical linear modeling (HLM) (Byrk and Raudenbush 1996). This approach was used because the DATOS subjects were recruited from multiple treatment programs, and thus client outcomes may be correlated within programs. HLM has the advantage of statistically controlling for the random effect of programs over and beyond the fixed effect of client characteristics. Therefore, the standard errors associated with the measures are not artificially attenuated. Substantively, this approach allows the identification of variation in program characteristics that contribute to the variation in client outcomes (intercept-as-outcome) and slopes predicting the client outcomes (slopes-as-outcome) model. HLM decomposes the relationship into a fixed portion (i.e., the base relationship common to all programs, Level-1) and a random portion (i.e., the intercept and slope estimates that vary from program to program, Level-2). The random component can be explained subsequently by program characteristics. Use of this approach increases confidence that the observed relationships are not due to idiosyncrasies of a single program. The HLM analyses were performed with HLM/2L (Byrk, Raudenbush, and Congdon 1996).

We began by building the client level (Level-1) model that included the intercept (treatment retention) and the slope (client characteristics, such as age and gender), with the client-level predictors centered around the program mean (see equation 1.1), where $r_{ij} \sim N(0,\sigma^2)$ and σ^2 is the residual variance at Level-1 after controlling for client-level predictors. The Level-1 units are clients, and the Level-2 units are programs. By centering the slopes around the program mean, the mean outcome (the intercept, $\beta_{(ij)}$) is the program-mean outcome. By subscripting the intercept and the slope by j, we allowed each program to have a unique intercept and slope.

$$Y_{ii} = \beta_{0i} + \beta_{1i} (X_{ii} - \overline{X}_{.i}) + r_{ii}.$$
 (1.1)

At Level-2, we were interested in how much the programs differed from each other. In other words, how much did the intercepts and the slopes vary. The parameters β_{ij} and β_{ij} vary across programs as a function of the grand mean and a random error (υ_{ij} for the intercept and υ_{ij} for the slope) in the Level-2 model (see Equations 1.2 and 1.3).

$$\beta_{0j} = \gamma_{00} + \gamma_{01} W_j + \upsilon_{0j}. \tag{1.2}$$

$$\beta_{1j} = \gamma_{10} + \gamma_{11} W_j + v_{1j}. \tag{1.3}$$

In our model, γ_{00} is the average number of days spent in DATOS treatment, and W_j is an indicator variable measuring a program characteristic. Thus, γ_{01} is the mean difference in retention between one program and another associated with W_j . Similarly, γ_{10} is the average regression slope across programs for a predictor variable such as age, and γ_{11} is the mean difference in age slope associated with W_j between one type of program and another. The υ_{0j} is the unique effect of program j on retention rates holding W_j constant, and υ_{0j} is the unique effect of program j in the age slope controlling for W_j . Combining the above Level-2 (program) equations with the Level-1 (client) equation gives us the following single equation:

$$Y_{ij} = \gamma_{00} (X_{ij} - \overline{X} ..) + \gamma_{01} W_j + \gamma_{10} (X_{ij} - \overline{X} ._j) + \gamma_{11} W_j (X_{ij} - \overline{X} ._j) + v_{0j} + v_{1j} (X_{ij} - \overline{X} ._j) + r_{ij}.$$
(1.4)

The program-level predictors explaining random variation in the intercept (β_{0j}) and slope (β_{1j}) were centered around their grand mean for ease in interpreting the results. The intercept with grand mean centering could then be interpreted as an adjusted outcome (retention) for clients whose value on X_{ij} is equal to the grand mean \overline{X} .. The errors r_{ij} are the Level-1 random effects, and the errors v_{0j} and v_{1j} are Level-2 random effects.

We started by examining the random variation in the outcome variables and the slope coefficients for predictors at the client level in separate models predicting retention and abstinence. We then included program factors to account for the random variation in the intercept and the slope, controlling for the client-level variables. Control variables at the client level included demographics (age, ethnicity, level of education, marital status), prior treatment history, cocaine dependence, criminal justice status, and negative reference group affiliation. Several program-level variables were evaluated for their effects on client outcomes via the intercept and the slopes, and only those with a significant effect were retained in the models. Because there were no significant program-level variables in the HLM predicting abstinence, we

used a logistic regression model to determine the client-level predictors that were associated with the dichotomous outcome (abstinence).

RESULTS

HIERARCHICAL LINEAR MODEL PREDICTING TREATMENT RETENTION

The average time spent in residential drug treatment was highly variable across the 16 programs, ranging from a low of 80.0 days to a high of 208.6 days. However, retention within programs was also highly variable; half of the programs (N = 8) had standard deviations over 100. Median retention rates ranged from 22 to 163 days across programs.

The initial random coefficient model containing only client-level variables showed small but significant random variation across different programs in treatment retention (the intercept, v_{0j} , p < .001). In addition, there was significant random variation in two predictor variables (the slopes, $v_{10j}p < .01$ and v_{11j} , p < .05), namely, negative reference group and pregnant/parenting women, respectively. In other words, retention among women in LTR programs randomly varied across programs for women who were pregnant or had dependent children and for women who had a negative reference group affiliation. Among the client-level control variables, age had a significant positive effect on retention (b = 3.10, p < .01). Having ever been married (b = -24.87, p < .05) and having prior drug treatment (b = -17.9, p < .10) were both negatively associated with retention, although the latter association was only marginally significant. (See Table 2.)

The model was then expanded to examine the effects of program characteristics that could account for the random variation in the intercept and the slopes with regards to retention. The final equation was as follows:

```
Y_{ij} = \gamma_{00} + \gamma_{10} \text{ (age)} + \gamma_{20} \text{ (White)} + \gamma_{30} \text{ (Hispanic)} 
+ \gamma_{40} \text{ (other ethnic)} + \gamma_{50} \text{ (high school)} + \gamma_{60} \text{ (prior drug treatment)} + \gamma_{70} \text{ (cocaine dependence)} + \gamma_{80} \text{ (ever married)} 
+ \gamma_{90} \text{ (legal supervision)} + \gamma_{100} \text{ (negative reference group)} 
+ \gamma_{110} \text{ (pregnant/parenting women)} + \gamma_{111} \text{ (percentage of pregnant/parenting women in programs)} + \upsilon_{0j} + \upsilon_{10j} + \upsilon_{11j} + r_{ij}.
```

The Level-1 predictors were centered around the group mean, and the Level-2 predictors were centered around the grand mean. One program-level characteristic was significantly associated with the random variation in the

TABLE 2: Results From Slope-as-Outcome Model for Women in Long-Term Residential Drug Treatment Programs (N = 637)

n)	1	23.72 3.11 -4.91		8.20 0.83 12.00 16.22	t <i>Ratio</i> 15.10*** 3.76***
٦)	-	3.11 -4.91 11.41		0.83	3.76*** -0.41
ገ)	-	-4.91 11.41		12.00	-0.41
ባ)	-	11.41		. — . – .	• • • •
	-	11.41		. — . – .	• • • •
	-			16.22	0.70
		10 20			-0.70
		10.08		23.28	-0.79
		-0.38		9.54	-0.04
High school degree, γ_{so} Prior drug treatment, γ_{so}				9.93	-1.80*
Cocaine dependence, γ ₇₀				14.35	-0.36
Ever married, γ _{a0}				10.41	-2.39**
Under criminal justice supervision, γ ₉₀				10.03	-0.25
Negative reference group, γ ₁₀₀				3.04	0.66
		5 O4		17.02	0.30
ho a	are	5.04		17.03	0.30
en,	γ	3.66		1.86	1.97*
	Variance	9			
)	Сотропе	nt (df	χ²	p Value
13	682.87	1	4	46.90	.00
84	78.21	1	4	34.16	.002
91	1436.97	1	3	21.51	.063
1 6	en,) 13 34	ho are en, γ _{ιιι} Variance O Compone	-0.38 -17.90 -5.09 -24.87 -2.53 2.02 5.04 ho are en, γ _{III} 3.66 Variance D Component 0 13 682.87 1 34 78.21 1	variance Component df 13 682.87 14 34 78.21 14	-0.38 9.54 -17.90 9.93 -5.09 14.35 -24.87 10.41 -2.53 10.03 2.02 3.04 5.04 17.03 ho are en, γ ₁₁₁ 3.66 1.86 Variance Component df χ² 13 682.87 14 46.90 34 78.21 14 34.16

^{*}p < .10. **p < .05. ***p < .01. ****p < .001.

intercept across programs. The percentage of pregnant and parenting women within programs significantly explained the random variation in retention rates among women who were pregnant or had dependent children (slope, υ_{1lj}). That is, women who were pregnant or had dependent children were retained longer in LTR programs that had a higher percentage of other such women. This variable reduced the between-program variation in retention rates among these women by 22.7%.

The interaction effect between program composition and parental status is illustrated in Figure 1, in which time in treatment for the two groups of women is compared for the lower quartile of programs (based on percentage of pregnant and parenting women) and the upper three quartiles. Pregnant and parenting women have increased retention in programs in which more

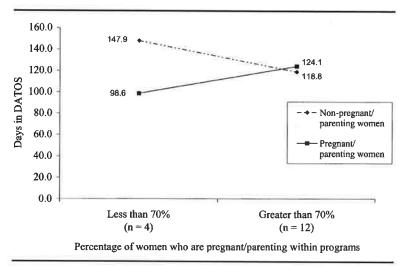


Figure 1: Interaction of Parenting Status With Program Composition on Treatment Retention

than 70% of the women are pregnant or parenting, as compared with the nonpregnant or non-parenting women, who have increased retention in the programs with lower percentages of pregnant and parenting women.

BIVARIATE COMPARISONS OF PROGRAM CHARACTERISTICS

The results of the preceding HLM analysis demonstrated that about 23% of the random variation in retention rates among pregnant and parenting women was explained when they were treated in programs with higher percentages of these women. This finding led us to hypothesize that programs with higher concentrations of pregnant and parenting women may differ from programs with lower concentrations of such women in the types of services they provide to address the service needs of these women. To explore this hypothesis, we examined other potential characteristics of programs that might be associated with a program's percentage of pregnant and parenting women. Treatment programs were classified based on the percentage of pregnant and parenting women, with the lower quartile composed of programs with less than 70% of women who were pregnant or parenting and upper three quartiles composed of programs with more than 70% of women who were pregnant or parenting. We then conducted bivariate comparisons of

TABLE 3: Characteristics of Programs by Percentage of Women Who Are Pregnant or Have Dependent Children

Program Variable (%)	Less Than 70% (n = 4)	Greater Than 70% (n = 12)
Priority admission for pregnant women	25.0	70.0
Offers special services for pregnant women	50.0	60.0
Provides prenatal care	75.0	83.3
Provides postnatal care	50.0	75.0
Provides transportation	50.0	58.3
Provides family services on-site	66.7	72.7
Mean number of services provided	10.3	11.5
(SD)	(3.9)	(3.6)
Program has good/excellent relationship with	· -/	()
family service agencies	50.0	75.0
Client had good relationship with counselor	69.7	86.5
Client received mental health services while		
in treatment ^a	29.0	42.1
Client discussed aftercare plan prior to discharge	e ^a 45.2	57.5

NOTE: n (number of programs) varies due to missing data from program administrator

program characteristics in relation to lower or higher percentages of pregnant and parenting women in these programs. Because the number of programs was relatively small (N = 16), we did not perform statistical tests on differences between the two program groups.

As seen in Table 3, programs with greater percentages of women who were pregnant or parenting differed from programs with smaller percentages of these women in several ways. A higher proportion of these programs had a priority on admission of pregnant women, provided specialized services for pregnant women, and provided several services that addressed women's needs, including prenatal care, postpartum care, transportation, and family services. Overall, these programs provided more services than programs with smaller percentages of pregnant and parenting women (M = 11.5 vs. 10.3, respectively). In addition, a greater proportion of these programs reported having good or excellent relationships with family service agencies. Based on client data from the follow-up interview, which was aggregated at the program level, a greater proportion of women in these programs reported that they had good relationships with their counselors, had received mental health services while in treatment, and had discussed aftercare plans with their counselors prior to program discharge.

a. Average percentage based on aggregated data from client follow-up interviews.

HIERARCHICAL LINEAR AND LOGISTIC REGRESSION MODELS PREDICTING POSTTREATMENT ABSTINENCE

Next, we examined abstinence rates among the subsample (N=226) of women from 15 programs (1 program was dropped from the follow-up study because of small N) who had completed the posttreatment follow-up interview. Abstinence rates ranged from a low of 11.1% to a high of 88.9% across programs, with an average of 44.8%. There was no statistically significant difference between pregnant/parenting women and others in abstinence rates.

In parallel with the previous HLM analyses for retention, we conducted HLM to determine the relationship of client and program characteristics with posttreatment abstinence. We first examined whether there was random variation across programs in abstinence rates (the intercept). We then examined whether women who were pregnant or had dependent children had higher rates of posttreatment abstinence when they were treated in programs that had higher percentages of other such women (the slope). The HLM results showed significant random variation across programs in the intercept—SD = .64, variance = .41, $\chi^2(13) = 25.55$, p = .02—but no variation in the slope. Although retention was a significant predictor for abstinence, no program-level variables significantly explained the random variation in abstinence rates.

Because no program-level variables were associated with random variation in abstinence rates across programs, we simplified the analysis by conducting a logistic regression model to test the relationship between client-level predictors and posttreatment abstinence. As seen in Table 4, women who stayed in the DATOS treatment episode 90 days or more were nearly four times as likely to be abstinent at follow-up. In addition, White women were about half as likely to be abstinent, as compared with African Americans, and women with prior drug treatment were marginally less likely to be abstinent, as compared with those with no prior drug treatment.

DISCUSSION

This study demonstrated that pregnant and parenting women who were treated in residential drug treatment programs with higher proportions of other such women were retained in treatment for longer periods of time. Moreover, a comparison of the characteristics of these programs, based on the percentages of pregnant and parenting women within programs, showed that in general, they provided more specialized services that addressed these

TABLE 4: Results From Logistic Regression Predicting Posttreatment Abstinence (N = 226)

Variable	Log Odds	Odds Ratio	95% Confidence Interval
Age	0.03	1.03	(0.97, 1.09)
Ethnicity (reference = African American)			,
White	-0.71	0.49**	(-0.22, 1.20)
Hispanic	0.05	1.06	(0.06, 2.06)
Other	-1.24	0.29	(-1.22, 1.80)
High school degree	-0.35	0.71	(0.12, 1.30)
Time spent in treatment episode (≥ 90 days = 1)	1.32	3.75***	* (3.12, 4.38)
Prior drug treatment	-0.52	0.60*	(-0.03, 1.23)
Cocaine dependence	0.65	1.92	(1.08, 2.76)
Ever married	-0.25	0.78	(0.11, 1.45)
Under criminal justice supervision	-0.11	0.90	(0.31, 1.49)
Negative reference group	-0.01	0.99	(0.87, 1.11)
Pregnant or have child younger than age 18	-0.44	0.64	(-0.05, 1.33)

^{*}p < .10. **p < .05. ****p < .001.

women's needs. Longer retention rates, in turn, were strongly associated with higher levels of posttreatment abstinence.

Among the client-level predictors, there was a trend for women with a history of prior drug treatment to have poorer outcomes—both retention and posttreatment abstinence. This finding is consistent with our earlier studies with DATOS, showing that individuals with longer treatment histories tend to be more severe in their drug use, including earlier drug use initiation and polydrug use; to be more criminally involved; and to have lower rates of posttreatment abstinence (Anglin, Hser, and Grella 1997; Hser et al. 1999). In particular, women with histories of prior treatment were more likely than women entering treatment for the first time to be diagnosed with antisocial personality disorder, suggesting that such women have even more complex treatment needs (Grella and Joshi 1999).

The findings from this study are consistent with a large body of research, including previous national treatment evaluation studies and other studies with DATOS, showing that retention is positively associated with posttreatment abstinence (Simpson 1981; Condelli and Hubbard 1994; Simpson, Joe, and Brown 1997; Simpson et al. 1999). Moreover, because programs vary in their client mix, in terms of severity of drug use and other problems, and in their therapeutic approach and effectiveness, variation in retention rates is a function of both client and program characteristics. A previous study with

DATOS showed that programs treating clients that were generally of a higher level of severity (i.e., more severe alcohol and drug use and greater psychological dysfunction) had shorter retention rates (Simpson et al. 1997).

This study further refines our understanding of the relationship of program characteristics with retention for women, demonstrating that pregnant and parenting women had higher rates of retention in programs in which there were higher concentrations of these women. Pregnant and parenting women tended to have lower retention rates than other women; 49% of pregnant/parenting women stayed in the DATOS treatment episode 90 days or longer as compared with 58% of other women, although this difference was not statistically significant, $\chi^2(1) = 3.45$, p > .05. In the HLM model for treatment retention, the coefficient for the variable indicating parental status was also nonsignificant. Given that retention was an important predictor of abstinence in the current study, however, the program variation in retention rates for different groups of women highlights areas through which treatment outcomes may differ. Although the analyses did not identify any program characteristics that were directly related to random variation in posttreatment abstinence rates, women who stayed in treatment for a minimum of 90 days were nearly four times as likely to be abstinent during the 12-month follow-up period, as compared with women who stayed in treatment less than 90 days. Thus, a program's characteristics may have an indirect effect, mediated through retention, on posttreatment outcomes.

In our examination of the characteristics of residential drug treatment programs, we found that programs in which there were greater concentrations of pregnant and parenting women offered more services, generally, and services regarding pregnancy and family needs, specifically. These programs also reported having better relationships with family service providers. Women in these programs were more likely to have received mental health services while in treatment, to have discussed aftercare plans with their counselors, and to characterize their relationships with counselors favorably. Taken collectively, these findings suggest that programs with higher concentrations of pregnant and parenting women provide more service-enriched environments to address the needs of these women and are more effective in forming positive therapeutic relationships with these clients. Especially noteworthy is that the programs participating in DATOS were typical, community-based drug treatment programs and not model demonstration programs on which most evaluation studies of treatment for pregnant and parenting women have been conducted.

These findings must be interpreted within the context of several limitations. First, we cannot discern the direction of the relationship between the proportion of pregnant and parenting women within programs and the services provided for them in these programs. The availability of these services may have induced more women to enter treatment in these programs, or these programs may have responded to the higher numbers of such women who entered their programs by offering more services for them. Future studies should address the interactive nature of client needs and program responsiveness to these needs, particularly regarding services for women. Second, the observational nature of the study limits our ability to make causal inferences. For example, although we showed that programs with higher concentrations of pregnant and parenting women differed from other programs in several ways, we cannot claim that these program differences per se underlie the variation in retention rates among pregnant and parenting women across programs. Third, the analyses of posttreatment abstinence were conducted with a considerably smaller subsample that had completed the 12-month follow-up interview; thus, these analyses may have lacked the statistical power necessary to detect more complex multilevel relationships.

Despite these limitations, this study contributes to the growing body of literature demonstrating the benefits of providing specialized treatment services for women, particularly those addressing family and mental health needs. Yet, concurrent with this emerging body of research is a movement away from providing specialized programs and services for women. One recent report showed that federal funding for women's drug treatment programs has dropped 38% since 1994 and that funding for programs targeting pregnant and postpartum women and their children is at only 10% of its 1995 level (Drug Strategies 1998). The authors of this report suggest that waning public concern over the effects of maternal crack abuse, coupled with welfare reform and changes in the delivery of health services, underlie the decreasing emphasis on specialized treatment for women. Drug treatment programs are increasingly operating within a managed care environment that places a premium on cost containment. Specialized treatment programs or services for women are vulnerable to budget cuts, as the broader range of services targeted to women's needs typically results in higher rates of patient costs (Grella et al. 1999). At the same time, another competing response to maternal substance abuse has been to impose criminal penalties on pregnant substance-abusing women (Chavkin, Wise, and Elman 1998). Within the context of this societal debate, the present study provides evidence suggesting that residential drug treatment programs that more effectively address women's service needs can yield improved treatment outcomes and ultimately help to ameliorate the individual and social costs of drug abuse among pregnant and parenting women.

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Christine E. Grella, Ph.D., is an associate research psychologist at the Drug Abuse Research Center in the Neuropsychiatric Institute, University of California, Los Angeles (UCLA). Her research interests are primarily concerned with the evaluation of drug treatment processes and outcomes, with a focus on women, dually diagnosed individuals, and adolescents, and on the organization of service delivery systems to these populations.

Vandana Joshi received her Ph.D. in sociology from UCLA and is currently a researcher at the UCLA Drug Abuse Research Center. Her research interests include substantive and methodological issues related to substance abuse, cohort analysis, and marriage and family.

Yih-Ing Hser is an adjunct professor in the Department of Psychiatry and Biobehavioral Sciences at UCLA. She is also associate director of the UCLA Drug Abuse Research Center. She received her Ph.D. in cognitive psychology from UCLA. Her major research interests include human learning and memory, drug use epidemiology and treatment evaluation, and development and application of statistical methodologies.

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Prospective patterns and correlates of quality of life among women in substance abuse treatment

Elizabeth M. Tracy^{a,*}, Alexandre B. Laudet^b, Meeyoung O. Min^a, HyunSoo Kim^a, Suzanne Brown^a, Min Kyoung Jun^a, Lynn Singer^a

- ^a Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106-7164, USA
- b Center for the Study of Addictions and Recovery, National Development and Research Institutes, Inc., 71 West 23rd Street 8fl., New York, NY 10010, USA

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ABSTRACT

Background: Quality of life (QOL) is increasingly recognized as central to the broad construct of recovery in substance abuse services. QOL measures can supplement more objective symptom measures, identify specific service needs and document changes in functioning that are associated with substance use patterns. To date however, QOL remains an under investigated area in the addictions field, especially in the United States.

Methods: This study examines patterns and predictors of QOL at 1 and 6 months post treatment intake among 240 women enrolled in substance abuse treatment in Cleveland, Ohio. The World Health Organization Quality of Life (WHOQOL-BREF) measure was used to assess physical, psychological, social and environmental domains. Hierarchical multiple regressions were conducted to identify correlates of QOL at 6 months post treatment intake.

Results: All QOL domains across the follow up time points improved significantly. However, QOL scores across domains remained below those of healthy population norms. Trauma symptoms significantly predicted Physical and Psychological QOL. Among treatment process variables, alcohol use was the sole significant factor associated with QOL and only for Environmental QOL. Recovery support and friends support for abstinence were consistently associated with QOL across all four domains.

Implications: This study suggests the usefulness of the WHOQOL measure as an indicator of functioning in substance abusing populations. Findings underline the importance of helping women deal with trauma symptoms and develop support for recovery. Further research is needed on the longitudinal relationship between QOL and substance use patterns.

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1. Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery from substance use disorders (SUD) as "a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life" (Center for Substance Abuse Treatment, 2007). Other recent data-driven definitions are consistent with that conceptualization (Belleau et al., 2007; Laudet, 2007). Common to these conceptualizations of recovery is enhanced QOL, a construct that incorporates objective functioning and the individual's subjective view of a range of clinical, functional, and personal variables (Bonomi et al., 2000). Though increasingly used in biomedical research, QOL is relatively new in behavioral research, especially in the addictions field.

Historically, when assessing well-being, the SUD field has used the 'health-related quality of life' (HRQOL) measurement model, a patient's perception of how his or her health status affects physical, psychological, and social functioning and well-being (Leidy et al., 1999). The frequently used Medical Outcome Study's (MOS) Short Form instrument series (e.g., the SF36 and SF12) focuses on limitations caused by disease and treatment (Stewart and Ware, 1989; Ware and Sherbourne, 1992). For example, items assess "health-limited" functioning bearing on daily tasks and social functioning (e.g., "Has your health limited you in walking one block?"). The pathology-focused HRQOL approach is informative but may be less useful for the recovery context, given the emphasis on improved functioning inherent in the prevalent definitions of recovery (Laudet et al., 2009; Laudet, 2011).

A more useful conceptualization of QOL in the context of SUD is overall QOL encompassing satisfaction with life in general, not solely in relation to disease-related limitations. The World Health Organization (WHO) defines QOL as "an individual's perception of their position in life in the context of the culture and value systems

^{*} Corresponding author. Tel.: +1 216 368 6294. E-mail address: elizabeth.tracy@case.edu (E.M. Tracy).

in which they live and in relation to their goals, expectations, standards and concerns" (World Health Organization Quality of Life Group WHOQOL, 1995). This conception includes domains typically included in definitions of behavioral health recovery, e.g., physical and mental health, social functioning, and living environment which includes safety, comfort and convenience of living environment and access to and availability of resources. These domains are cited by individuals in recovery as key priorities (Laudet and White, 2010) and consistent with experts' guiding criteria for SUD treatment evaluation: reduction in substance use, improvement in personal health and social function, and lowered public health and safety risks (McLellan et al., 1996).

1.1. QOL, SUD and treatment outcomes

The strongest argument for considering QOL as an outcome domain of SUD treatment comes from studies examining the association between QOL and subsequent symptoms. For example, two studies were conducted in a sample of community-based formerly polydrug-dependent persons who, at recruitment, ranged in drug/alcohol abstinence duration from 1 month to over 10 years. In cross-sectional analyses, overall QOL satisfaction increased gradually from early recovery (under 6 months abstinent) to stable (3 years and over) abstinence; abstinence duration correlated positively with QOL satisfaction and accounted for 9% of the variance in QOL satisfaction (Laudet et al., 2006). In a prospective study, longer abstinence duration at baseline significantly predicted higher levels of QOL satisfaction one year later (Laudet and White, 2008). Another study reported that QOL satisfaction at the end of outpatient treatment significantly predicted commitment to abstinence (Laudet and Stanick, 2010). In opiod addiction treatment, improvement in health related QOL was associated with more successful treatment outcomes (Karow et al., 2010). Thus QOL assessments can serve as both an evaluation and a diagnostic tool (Rudolf and Watts, 2002).

1.2. QOL, trauma and social support

QOL is consistently poorer among persons with active SUD and treatment seekers than among cohorts without SUD or chronic psychiatric conditions (Donovan et al., 2005). Impairments in almost all life domains are noted as a function of physical and/or psychiatric comorbidity (Bizzarri et al., 2005). Rudolf and Priebe (2002) found that women in detox with alcoholism and co-occurring depressive symptoms had lower subjective QOL than women with no depressive symptoms, particularly in relation to their family situation and life as a whole. Heroin abusers with personality disorders have been shown to score lower on QOL (Fassino et al., 2004). QOL generally improves with abstinence (Kraemer et al., 2002; Villeneuve et al., 2006), especially mental functioning (Foster et al., 2000; Dawson et al., 2009). Thus far, the direct effect of SUD treatment on QOL has not been examined independent of treatment effects.

Overall, QOL research in the SUD field remains in its infancy and there are many unanswered questions. The influence of trauma symptoms on QOL over time, particularly among women, is not well understood. While there has been interest in assessing QOL following trauma, particularly childhood trauma (Janssens et al., 2008), not all studies show strong connections between exposure to trauma and subsequent QOL (Ventegodt, 1998). Grella's (2008) literature review reveals that compared to men, women tend to enter treatment with greater psychological distress, mental health problems and exposure to past and current violence and trauma. Moreover, women's spouses and partners may contribute to continued victimization and emotional problems, thereby adversely affecting physical health and QOL (Dawson et al., 2007). In addition, little is known about the role of social support as a predictor

or moderator of QOL in SUD populations. It might be expected that greater social support would be associated with higher OOL; in fact there is some evidence that family support might be a stronger predictor of QOL than exposure to traumatic events, as evidenced by Grills-Taquechel et al. (2011) QOL study following exposure to the Virginia Technological Institute shootings. Greater partner support significantly predicts health related QOL, particularly mental QOL, among injection drug users who were HIV-infected (Preau et al., 2007). Understanding the relationship between social support and QOL is important, since the social domain is especially critical to the recovery process. Studies have documented the enhanced need for and usefulness of social support, especially early on in posttreatment recovery (Humphreys et al., 1997; Laudet et al., 2004, 2006) in the context of a potential erosion of social networks as the individual pulls away from substance involved associates but has not yet established a sober network of friends (Ribisl, 1997; Tracy and Johnson, 2007; Tracy et al., 2010). Women may enter treatment with less social resources as compared to men; fewer social supports among women have been shown to negatively influence both treatment access and retention (Greenfield et al., 2007). In addition, social support provided through social networks can be predictive of treatment outcomes, with greater support for sobriety predicting less substance use (Warren et al., 2007; Wenzel et al., 2009). However, little is known about the role of social support as a predictor of QOL among women with SUD.

1.3. Study aims

The objectives of this study are to (1) describe trajectories of QOL in four domains (Physical, Psychological, Social and Environmental) from intake to 1- and 6 month-post intake among SUD treatment enrolled women; and (2) to identify the role of sociodemographic, clinical, treatment and social support domains as correlates of QOL changes at six months post treatment intake, controlling for baseline levels of QOL. This appears to be the first study in the US to examine these questions longitudinally and one of the few to use the generic/overall QOL model in SUD populations.

2. Method

2.1. Procedures

Data were originally collected from 305 women participating in a study of the role of personal social networks on post treatment functioning. Women were considered study eligible if they had been in treatment for at least one continuous week and had a diagnosis of substance dependence. Substance dependence was defined as a DSM-IV diagnosed substance dependence within the past 12 months of entry into the study for at least one drug, including alcohol. Women with a known diagnosis of schizophrenia or taking medication prescribed for a major thought disorder were excluded. Participation was voluntary; participants signed an informed consent document prior to their involvement. Overall participation rate of those eligible was 84%.

Face to face interviews were conducted at 1 week (T1), 1 month (T2) and 6 months (T3) post treatment intake between October 1, 2009 and August 30, 2011. All interviewers had been trained in research interviewing, research ethics and the use of a computerized assisted personal interview (CAPI). The interviews took on average 2 h to complete. The study was reviewed and approved by the Case Western Reserve University Internal Review Board for the protection of human subjects. A Certificate of Confidentiality was secured from the National Institute of Health. Participants received a \$35 gift card, plus reimbursement for travel at each interview.

Of the 305 baseline interviews, one interview was omitted from analysis due to incomplete data; in addition 4 women were not included in the follow up interviews due to medical reasons (including 3 deaths unrelated to the study) and 5 refused continued participation. Thus, 295 women were available for follow up. Of these, 55 women were lost to follow up, leaving a study sample of 240 women who completed the Time 3 follow up interview, representing an 81.3% retention rate.

All women were in county funded specialized treatment programs for women: 173 in intensive outpatient and 67 in non-medical community residential substance abuse treatment. Participants were 37.3 years old on average (SD = 10.4, R = 19-43). 62.9% (n = 151) identified as African American. 45% had less than a high school diploma or GED. Three-fourths of the women (75.5%, n = 172) received food stamps or welfare assistance. Nearly two-thirds of respondents were diagnosed with

cocaine dependence (62.1%, n = 149) and 45.5% (n = 114) and 41.3% (n = 99) respectively were diagnosed with alcohol and marijuana dependence. Over half (58.6%) were dependent on more than one substance.

Attrition analysis found three statistically significant differences. Those lost to follow up were on average 3 years younger than those interviewed (p=.009), were more likely to be non-African American women (p=.016), and to have been residential treatment (p=.001). None of the other variables examined (dual disorder status, homelessness, legal involvement, number of SUD and trauma symptoms) differed significantly.

2.2. Measures

Demographic information (age, education, race/ethnicity) and the number of co-occurring mental disorders (generalized anxiety disorder, posttraumatic stress disorder and mania/hypomania and major depression/dysthymia) were assessed at intake via the computerized Diagnostic Interview Schedule IV (CDIS; Robins et al., 1981; Helzer et al., 1985). The CDIS, based on DSM-IV criteria, has demonstrated validity and reliability (Robins et al., 1999). Based on the past 12 month presence of mental disorders as determined by the CDIS-IV, a continuous variable was created of the count of co-occurring mental disorders. Race was a dichotomous variable coded as African American/non-African American. Education was also coded as a dichotomous variable (less than high school/more than high school education).

The Trauma Symptom Checklist-40 (TSC-40; Elliott and Briere, 1992; Zlotnick et al., 1996) was used at intake to evaluate symptomatology associated with childhood or adult traumatic experiences. The TSC-40 is a 40-item self-report instrument. Symptom frequency over the prior two months was rated, using a four point Likert-type scale ranging from 0 (Never) to 3 (Often). Consistent with other reports of reliability of this measure (Briere, 1995), in this study, Cronbach alpha was .931 for the total scale.

Two instruments measured social support at T3. The Social Support for Recovery Scale (Laudet et al., 2000a), a 7-item scale, assessed the extent to which people in the participant's life supported recovery, (e.g., "The people in my life understand that I am working on myself"). Participants indicated their level of agreement with each statement on a 4-point Likert scale ranging from 1 (Strongly Agree) to 4 (Strongly Disagree). The Friend's Support for Abstinence Scale is an 8 item scale developed from the Social Network Social Influence Scale (Collins et al., 1990) and adapted by Humphreys et al. (1997) to measure friends' support of recovery efforts (e.g., "My friends offer advice about quitting drugs or alcohol, without nagging"). Participants rated each item using Likert scale response options ranging from 1 (Never) to 5 (Often). Reliability of both scales was satisfactory, with alphas of .881 and .717 respectively.

The Treatment Services Review (TSR) provided a quantitative assessment of treatment process variables at T3 (McLellan et al., 1992). Three TRS items were used to determine the extent of alcohol use ("How many days in the past 30 have you had at least one drink of alcohol?"), drug use ("How many days in the past 30 have you used any illegal drug or prescribed drug in a non-prescribed manner?"), and 12 step meeting attendance ("How many times in the past 30 days have you attended an AA/NA/CA or any other 12 step meeting?"). In previous research, test–retest reliability for the total TSR was high for in-person interviews spaced 1 day apart. Tests of concurrent validity showed the ability to discriminate different levels of treatment services (McLellan et al., 1992).

Quality of Life at each assessment point was measured by the WHOQOL-BREF (World Health Organization Quality of Life Group WHOQOL, 1995, 1998; WHOQOL Group, 1998; Bonomi and Patrick, 1997). The 26-item BREF is an abbreviated version of the WHOQOL-100. It incorporates items from each of the 24 QOL facets included in the longer form plus two 'benchmark' items on overall QOL and general health, retaining the comprehensiveness and psychometric properties of the 100. The BREF yields four domain scores: Physical, Psychological, Social and Environmental that correlate around 0.9 with the WHOQOL-100 domain scores (World Health Organization, 1997). Psychometric properties are excellent and comparable to that of the full instrument for internal consistency, construct and discriminate validity and sensitivity to change (Skevington et al., 2004). Reliability of the QOL domains as measured by Cronbach's alpha was moderate to high: Physical .806, Psychological .792, Social .642, and Environmental .769.

Previous research using the WHOQOL-BREF with a general population has established some normative mean scores. Using a random sample of adults in Australia, Hawthorne et al. (2006) reported the following domain mean scores and standard deviations: Physical Domain, mean=73.5 (SD=18.1), Psychological Domain, mean=70.6 (SD=14), Social Domain, mean=71.5 (SD=18.2), Environmental Domain, mean=75.1 (SD=13). In a Danish general adult population, Noerholm et al. (2004) observed the following: Physical Domain, mean=77 (SD=17), Psychological Domain, mean=69 (SD=16), Social Domain, mean=69 (SD=18), Environmental Domain, mean=74 (SD=16).

2.3. Data analysis

Frequencies and distributions were examined for all variables to determine if acceptable levels of skewness (<2) and kurtosis (<7) were evident (Curran et al., 1996). Two interval level variables with skewed distributions were re-coded as

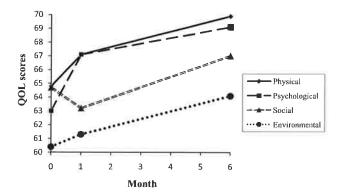


Fig. 1. OOL changes over 6 months.

dichotomous variables; days of drug use, and days of alcohol use in past 30 were re-coded as any days in past 30 (Yes = 1, No = 0). Bivariate correlations were examined to identify significant relationships among variables and multicollinearity was assessed using tolerance and variance inflation factor (Allison, 1999).

Repeated measures analysis of variance (ANOVA) was used to compare the four QOL domain scores at T1, T2 and T3 (Aim 1). When the overall test yielded significant group differences, follow-up pair-wise tests were conducted with a Greenhous-Geisser correction.

Hierarchical multiple regressions were conducted to address Aim 2, to identify predictors of QOL at T3. Variables correlated (p < .1) at the bivariate level were entered using block entry with baseline QOL entered in Step 1, demographic and diagnostic characteristics (age, race, education, number mental disorders, trauma symptoms) in Step 2, treatment process (any alcohol/drug use, number 12 step meetings) in Step 3, and social support (friend support for abstinence and recovery support) in the final step.

3. Results

3.1. Sample characteristics and correlations at T3

Table 1 shows descriptive information and correlations among the variables used in the multivariate analyses. Participants had on average 1.6 mental disorders in addition to a SUD; nearly three-fourths (73.2%, n=175) had co-occurring mental disorders. Mean score on the TSC was 43.2 (SD=21.3). At Time 3, 16% reported alcohol use, while 6% reported drug use; women reported a mean of 12.7 days of attending AA or other 12-step meeting. While being in treatment was not correlated with QOL domains, it should be noted that at T2 210 women (87.5%) remained in treatment and by T3 70 women (29%) reported being in treatment (at the same or different program).

Being older was associated with lower Physical QOL (r = -.167) at Time 3, while non African American status was associated with lower Psychological QOL(r = -.139). As Table 1 indicates, the two measures of social support were positively correlated (r = .508); in addition, the four QOL sub-scales were positively correlated, with coefficients ranging from .445 to .589. Higher TSC scores were associated with lower QOL in all domains; friend and recovery support were positively correlated with all four QOL domains. The number of mental disorders was negatively associated with all QOL domains except the Environmental domain. Drug use was significantly correlated with lower QOL in all domains; alcohol use was negatively correlated with all QOL domains with the exception of social QOL. Twelve step attendance was weakly correlated with the Psychological and Environmental QOL domains only.

3.2. QOL Changes

Fig. 1 graphs QOL domain specific mean scores at the three data collection points. There were statistically significant differences in mean ratings of QOL across the follow up points for all domains: Physical QOL (F(1.917, 460) = 10.172,

1.1

	1	2	m	4	2	9	7	00	6	10	11	12	13
1, Age													
2. Non-African American	221"												
Education (1 = high school or above)	.292.	660											
4. # of mental disorder	.131	193"	100										
5. Trauma symptoms	014	.157	036	.399.									
Any alcohol use (1 = yes)	025	011	.032	.104	.172"								
7. Any drug use $(1 = yes)$	- 039	.103	440.	.064	080	420							
8. Attend AA/NA/CA	.129*	680	.145	.026	040	145	- 007						
9. Recovery support	.178"	044	.202	102	106	123	_162	228					
10. Friends support	.124	.116	.118	043	134	139	-147	222	508				
11. Physical QOL	167"	079	008	259"	-426	- 140	_164	101	282	000			
12. Psychological QOL	.028	139	040	204"	-419"	-211	-177"	181	471	350"	-002		
13. Social QOL	.041	055	049	131	-286	- 093	_152	101.	440		1000		
14. Environmental QOL	.002	.060	.104	049	300	269	155	.175	413	.473"	.558	.579**	.556"
M	37,3	1	ı	1.6	43.2	,		12.7	0 80	21.1	0 00	0	1
SD	10	1	ı	1.4	21.3			10.1	0 V	5.1.	0.00	0.50	0.70
94	ı	37%	55%	1	1	16%	%9		о г I	0.0	1.02	10./	77'0

4

Vote: 6–14 variables measurer 7 p < .05. -- n < .01 p<.000), Environmental QOL (F(1.948,460) = 6.076, p = .003), Psychological QOL (F(1.901, 456) = 16.407, p<.000) and Social QOL (F(1.942,456) = 3.337, p = .038). Post-hoc tests revealed that Physical QOL was significant from T1 to T3 (p<.000), and T2 to T3 (p=.031) but not T1 to T2 (p=.093). Psychological QOL was significant from T1toT2 (p<.000) and T1 toT3 (p<.000), but not T2 toT3 (p=.148). Environmental QOL was significant from T2 to T3 (p=.034) and T1 to T3 (p=.006), but not T1 to T2 (p>.05). Social QOL was significant from T2 to T3 (p=.495). In each of these instances, the mean QOL score at the follow up point was higher than at the previous interview, indicating positive improvements in QOL, except for a decrease in mean Social QOL from T1 to T2, though this did not approach significance (p=.822).

3.3. Regression analysis of QOL

Controlling for the relevant T1 QOL score, Table 2 shows results of the hierarchical multiple regression analysis on QOL domain scores at T3. While race and number of mental disorders were significant at the bivariate level for one or more QOL domains, they did not remain significant in the final step of the models when the trauma and social support variables were included. Controlling for T1 Physical QOL (β = .38), higher Physical QOL at 6 month post intake ($R^2 = .42$) was associated (p < .05) with younger age ($\beta = .17$), fewer trauma symptoms (β =-.19), greater perceived recovery support (β = .16) and friend support (β = .15). Improved Psychological QOL at 6 month post intake ($R^2 = .43$) was associated (p < .05) with fewer trauma symptoms ($\beta = -.15$), and greater perceived recovery support (β = .20) and friend support (β = .16), controlling for T1 Psychological QOL (β = .36). Likewise, Environmental QOL at 6 month post intake ($R^2 = .41$) was associated with (p < .05) less alcohol use in past 30 days ($\beta = -.17$), and greater perceived recovery support (β =.18) and friend support (β =.28), controlling for T1 Environmental QOL (β = .30). After controlling for T1 Social QOL (β = .26). Social QOL at 6 month post intake $(R^2 = .35)$ was correlated (p < .05)solely with the support measures, recovery support (β = .28) and friend support (β = .21).

4. Discussion

4.1. Strengths and limitations

This paper examined changes in and correlates of QOL among women with SUDs. This study used a cross-culturally standardized measure of QOL, the WHOQOL BREF, which to our knowledge has not been used with this population in the United States. This QOL measure helps to determine the social context within which SUD treatment and recovery occur by asking about satisfaction with social relationships and environmental living conditions in addition to individual health related and emotional factors. The study used a longitudinal design with repeated measurements and obtained a high retention rate among a large sample size of low income women, the majority with dual disorders. In terms of generalizability, study findings may be limited to low income inner city women served by county service systems. In this study, there were a limited number of treatment process variables included and there was little variance in substance use, limiting our ability to examine past 30 day substance use as a predictor of QOL; we were also not able to examine whether or not reduction of substance use occurred in this study. In addition, the contribution of QOL or the way in which QOL changes might influence treatment outcomes, maintenance of outcome or long term recovery is not addressed in his studv.

 Table 2

 Hierarchical multiple OLS Regression with QOL domains.

QOL domain (T3)	Physical			Psychological	lai		Social			Environmental	lati	
	В	SE(B)	β	89	SE(B)	β	eq.	SE(B)	β	8	SE(B)	8
Step 1 QOL domain (T1) Sten 2	.60 \textstyle \textstyle \textst	.60 .06 ΔR² = .28" F(1,235) = 91.86""	.53	.52 \textstyle \textstyle R^2 = .29 \textstyle \textsty	.52 .05 \Delta R^2 = .29*** F(1,233) = 94.73****	.54	.40 \triangle R^2 = .16***	.40 .06 .06 F(1,235)= 44.10***	.40	.46 \triangle R^2 = .19***	.06 F(1,236)=54.30	.43
QOL domain (T1) Age Race	,45 22	.07	.40	.43	2.20	01	34	.07	.34""	.39	.07	.37"
Education # of mental disorder Trauma symptoms	-1.06 20	.86 .06	07	15	.81	101	22 - 14	1.02	01	1.19	2.09	.03
Step 3	$\Delta R^2 = .06^{**}$	$\Delta R^2 = .06$ " $F(4,235) = 30,02$ "		$\Delta R^2 = .02 \text{ ff}$	$\Delta R^2 = .02 \text{ F}(4,233) = 25.63^{***}$		$\Delta R^2 = .02 F(3)$	$\Delta R^2 = .02 F(3,235) = 16.45$	ŗ.	$\Delta R^2 = .02^* F($	$\Delta R^2 = .02^{\circ} F(3,236) = 20.78^{-1}$	01*1
OOL domain (T1) Age	.45	.07	.40***	.42	.07	.43	.33	90*	.34""	651	.07	37
Race Education				86	2.17	02				Š	i d	6
# of mental disorder	76'-	.85	07	09	.80	-101	21	1.01	10	.94 4	2.03	:03
Trauma symptoms	19	90'	20	12	90'	.14.	13	.07	12	-,10	.05	12
Drink of alconol Use of illegal drug	-2.64 -7.52	3.29 5.05	-05	-6.21	3.20	12	12.07	1 70		-8.97	3.00	-19
Attend AA/NA/CA	A.P.2 = 0.1 F.7	A R2 = 01 E/G 2351-21 04***			.10	12	,	.13	.07	1	4.62	.12
Step 4) I I O = NZ	0,233)-21,04			r(7,233)=17.17		$\Delta R^2 = .02 F($	F(5,235)=11.35		$\Delta R^2 = .07$ " I	F(6,236) = 14.98"	
QOL domain (T1) Age	.42	.07	.38***	.35	90.	.36	.25	90.	79	.32	90.	30
Race				-1.77	2.06	05						
Education # of mental disorder	73	6	90	ŗ	ŗ	Č	i	,		.70	1.87	02
Trauma symptoms	18	90.	-19	-,13	50.	10.1	12. 21.	92	.01 _17	80	30	, C
Drink of alcohol	-1.63	3.14	03	-5.46	3.00	11.	!		7	18.21	.73	17.
Use of illegal drug	-4.71	4.85	90*-	55	4.54	01	-5.64	5.02	90'-	18	4.24	01
Attend AA/NA/CA				80.	.10	.05	80	.12	04	.05	60.	.03
Recovery support	.65	.25	.16	77.	.24	.20	1.24	.29		.65	.22	.18
Friends support	.54	.21	.15	.55		.16	.84	.25	.21"	889	.19	.78
	$\Delta R^2 = .06$	$\Delta R^2 = .06^{} F(8,235) = 20.49^{} R^2 = .42^{}$	² = .42	$\Delta R^2 = .09$	F(9,233) = 18.95 F	R ² = .43""	$\Delta R^2 = .16^{***} F$	F(7,235)=17.77" R2	2 = .35***	$\Delta R^2 = .13^{} F$	F(8,236)=20.11*** R2	2 = 41
Note Riank enaces indicate that the warrinkle was sont significant at the Lin	t the vertible we	A de la constante de la consta	who there are	the state of the s								

Note. Blank spaces indicate that the variable was not significant at the bivariate level and therefore not included in the model. p < .05. p < .05. p < .01. ... p < .01. ... p < .001.

4.2. QOL of women with SUD

Although QOL at T3 showed significant improvements relative to intake, all 4 QOL domains remained significantly below scores reported for non-substance dependent populations (Noerholm et al., 2004; Hawthorne et al., 2006). This suggests that women with SUD and/or dual disorders continue to experience poorer functioning than does the general population. These results are consistent with previous findings (Bizzarri et al., 2005) of lower QOL domain scores in substance abusing and dual disordered populations compared with the general population. However, it is difficult to draw meaningful comparisons of QOL due to the lack of U.S. norms for the WHOQOL-BREF and an appropriate control group of low income inner city women. In addition, whether lower QOL predicts greater vulnerability to relapse remains a question for future research. There is however, emerging evidence that QOL satisfaction at the end of outpatient treatment significantly predicts commitment to abstinence, a motivational construct that is a strong predictor of sustained abstinence (Laudet and Stanick, 2010) and prospectively predicts sustained abstinence up to two years later (Laudet et al., 2009).

In this study, low QOL scores at intake suggest that women may start treatment at a relative disadvantage in terms of their perceived quality of health status, social context and environmental conditions which may influence their response to treatment services in ways different than their substance use alone. It is important to point out that Environmental QOL was rated the poorest of all domains at all time points, as shown in Fig. 1. This may reflect the fact that many women in this study had low incomes and lived in poor neighborhoods, environmental factors that might complicate access to treatment and supportive services. We also observed a decrease in social QOL at the one month follow up interview. This may indicate a vulnerable time point for women in treatment during which they may have extricated themselves from some substance-involved social relationships but not replaced them with more appropriate social outlets; social support or network interventions might be timely and relevant at this point in time as well.

4.3. Predictors of QOL

Treatment process variables, including recent alcohol and drug use, whether or not women were in treatment, and number of 12-step meetings attended were mostly not statistically significant in the regression analysis of QOL domains at T3. Only the amount of alcohol used within the past 30 days was significant, and only for Environmental QOL. This finding suggests that the extent of substance use may not be the most salient factor in determining life satisfaction in this population, and implies the need for treatments and services focused on other areas of functioning in addition to sobriety or reduction of use, such as trauma symptoms, living conditions, and social support.

One area that appears to impact QOL significantly more than substance use as measured in this study is the degree of trauma symptoms. In this study, trauma symptoms were significant correlates of Physical and Psychological QOL domains. These results are supported by previous literature that has identified a high rate of trauma and histories of sexual violence among female substance users (Root, 1989; Singer et al., 1995, 1997). For this reason, previous researchers have endorsed the need for more trauma informed interventions and services for this population (Najavits et al., 1997; Harris and Fallot, 2001), as well as integrated treatment models for trauma symptoms and substance abuse.

Recovery support and friends support for abstinence were significant contributors to QOL across all four domains. Regardless of substance use, 12 step meetings attended, and trauma symptoms,

social support remained a significant factor associated with higher of QOL. This suggests that enhancing social support for recovery/abstinence may contribute to improved QOL for women in substance abuse treatment.

4.3.1. Implications. The findings from this study have the potential to inform service development by identifying specific areas of functioning that are impaired for women in this population. Services and interventions may be developed or modified by taking into account the chronology of improvement in both QOL and recovery maintenance, and specific service needs at various stages of recovery, both during treatment and post treatment. The importance of trauma informed services for substance abusing women are supported by this study's findings. Additionally, the important role of social support, especially support related to recovery, is strongly supported by these data. This underscores the importance of targeted treatment interventions that help women to enhance support for recovery provided to them from their social networks.

4.3.2. Future research. This study reinforces the utility of the WHO-QOL measure as a potentially useful indicator of functioning in substance abusing populations. However, more longitudinal studies are necessary to understand QOL and changes in QOL over time as risk or protective factors for individuals with SUD. Additionally, the relationship between substance use, sobriety maintenance, and QOL remains unclear. Whether substance use determines QOL, QOL determines substance use, or some other factor predicts both substance use and QOL remains unanswered. Future studies might use the WHOQOL to examine the causal processes in QOL and recovery maintenance over time. In addition, the relationship between different types of treatment interventions delivered (e.g., cognitive behavioral, skills building, psychoeducational) and quality of life domains could be examined. Continued research on OOL would increase our understanding of treatment outcomes in the broader context of a recovery oriented model of treatment.

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Contributors

Elizabeth Tracy is the principal investigator and Alexandre Laudet, Meeyoung Oh Min and Lynn Singer are co-investigators of the grant that supported this research. Elizabeth Tracy conceptualized the paper and wrote the initial and final drafts. HyunSoo Kim and MinKyoung Jun undertook the data analysis and literature searches. Alexandre Laudet wrote the background on QOL and measures and Sue Brown wrote the discussion section. All authors contributed to drafting and reviewing the manuscript and have read and approved the final manuscript.

Conflict of interest

The authors have no conflicts of interests.

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Renew Wellness & Recovery

Renew Wellness & Recovery will be a twelve bed facility that provides a residential level of care for women ages 18-50 struggling with co-occurring substance use disorders and mental health issues. The program is designed to provide residential therapeutic services for 90 days on a voluntary basis. All residents will receive treatment every day of the week and up to seven hours a day as outlined in the daily schedule (see attached). All treatment plans will include goals that address the specific needs of the resident based on her unique presenting issues and objectives. A wholeness approach to treatment will be utilized and will include services that address each resident's physical wellness, mental wellness, emotional wellness, and spiritual wellness.

Therapeutic Community & Group Influence

The treatment that will be provided to residents of Renew Wellness & Recovery consist of individual, family, and group therapy components. The number of residents that can be served in the program has a significant impact on the effectiveness of outcomes. This is most evident in the group therapy component of the program. Research indicates that an optimal size for a therapeutic group is between 8-12 members. This has been determined based on the significant impact that peer support, feedback, commonalities, connection, and diverse views contribute to the treatment process. In addition, research also indicates that the development of a supportive social network that focuses on recovery is a significant factor in long-term outcome effectiveness; therefore, the group dynamic provides the opportunity for a residents to be exposed to the elements in developing such a network for herself.

Renew Wellness & Recovery's request for 12 residents in the program is so that optimal group member numbers can be maintained. As identified on the daily schedule, group and individual work will be conducted during the same treatment hours. Thus, 1-3 residents may be in an individual or family session while the remaining residents are in a group session. Therefore it is my professional opinion that in order to ensure an optimal treatment environment, offering 12 residential beds is not only aligned with the empirical literature but also allows the program the opportunity to provide residents the most effective therapeutic services.

In addition, residents will be entering and exiting the program on an average of every 90 days. Therefore, requiring a transitional period of two days where the number of residents will be lower. All residents in the program deserve to receive the same effectiveness in the group process; thus, being able to maintain the optimal group level is critical for providing effective therapeutic services every day a resident is in the program.

The program will not only provide residents with services to assist with healing from the disease of addiction, but will also, provide treatment for the underlying issues that have contributed to the development and maintenance of the disease. Trauma and posttraumatic stress disorder are two significant factors that will be addressed through the treatment program. As well, family work and recovery support development will be primary components to improve the success rates for long-term outcome effectiveness.

Treatment Providers

All personnel employed at Renew Wellness & Recovery will be required to meet and adhere to the training and conduct protocols outlines in the policy & procedure manual (P&P) approved by the Utah State Department of Health and Human Services. The P&P outlines procedural requirements for behavioral management, safety precautions, expectations, code of conduct, background screening, and minimum requirements for each position of employment.

The clinical team that will be providing therapeutic services daily to the residents will consist of licensed clinicians and substance use counselors, which are regulated and overseen by the Department of Professional Licensing (DOPL). Therefore, all members of the clinical team will be held to a standard that adheres to ethical guidelines, as well as, requires continual education to ensure competency of the provider at a level determined by DOPL.

The medical team will provide services to the residents upon intake to the program and as needed throughout the program. A medical doctor will review documentation from detoxification centers and/or other referring sources to determine readiness of the resident to participate in the program, as well as, address any chronic medical conditions. All residents will be required to be medically cleared and stable by a physician or hospital facility before being allowed admission into the program. A psychiatrist will provide medication management for any resident with prescription medications throughout the program. Prescriptions will be monitored and administered by the program and residents will not be allowed access to medications until discharged from the program.

The advisor and support team will provided observation of residents on a 24/7 schedule and will report any personal needs or behavioral issues to the Clinical Director immediately upon discovery. In addition, specialist will provide services to residents through experiential and physical activities. These specialist include yoga instructors, fitness coaches, nutritional coaches, recovery mentors, art therapist, and recreational therapists.

Program Objectives

The objective of Renew Wellness & Recovery is to provide a resident with the tools, resources, and healing that will allow for reintegration into her family and community as a productive member of society free from the debilitating disease of addiction. This objective will be realized through the use of evidence based practices for substance use and mental health treatment, such as, cognitive behavioral therapy, mindfulness, relapse prevention, behavioral modification interventions, and experiential activities. As well as, through the development of prosocial support networks, physical wellness improvements, spiritual connections, and collaborative aftercare support.

Thank your for your consideration in this matter,

Deborah M. Wayman, MS-MHC, CMHC

Clinical Director

Daily Program Schedule

PREMEW WILLINESS & RECOVERY PROGRAM OUTLINE

T	, C		T CARMON TO	carl a State Concern	TORAT.		
IME	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7:30 a.m.		Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	
8:30 a.m.	Breakfast	Fitness	Fitness/Yoga	Fitness	Fitness/Yoga	Fitness	Breakfast
9:00 a.m.	Family				2		
9:30 a.m.	Visitation	Daily Prep/Shower	Daily Prep/Shower	Daily Prep/Shower	Daily Prep/Shower	Daily Prep/Shower	Fitness/Yoga
10:00 a.m.		Group/Individual	_	Group/Individual	Group/Individual	Group/Individual)
10:30 a.m.		Therapy	Therapy	Therapy	Therapy	Therapy	
11:00 a.m.							Daily Prep/Shower
17.50 p.m.	Town	1					
12:00 p.m.	Lunca	Canch	Lunch	Lunch	Lunch	Lunch	Lunch
12:30 p.m.							
1:00 p.m.	Family Group	Group/Individual	Experiential	Group/Individual	Experiential	Group/Individual	Experiential Activity/
1:30 p.m.		Therapy	Activity	Therapy	Activity	Therapy	Expressive Therany
2:00 p.m.						4	
2:30 p.m.							
3:00 p.m.	Relaxation	Break		Break		Break	
3:30 p.m.		Group/Individual		Group/Individual		Group/Individual	
4:00 p.m.		Therapy	Personal Time	Therapy	Personal Time	Therapy	Breat
4:30 p.m.				Break			Process Grain
5:00 p.m.				Nutrition/Food			Thorn seems
5:30 р.т.		Break		Prep/Dinner Group			
6:00 p.m.	president and the second	Dinner	Dinner	•	Dinner	Dinner	Personal Time
6:30 p.m.							armir immorra
7:00 p.m.	Dinner	Process Group	Group	Process Group	Group	Process Group	Dinner
7:30 p.m.							
8:00 p.m.	Movic/Games	Journaling/	Journaling/	Journaline/	Journaline/	Groun	Tournaling
8:30 p.m.		Assignments	Assignments	Assignments	Assignments	Activity/Recovery	Assignments
9:00 p.m.	P=3	Meditation	Meditation	Meditation	Meditation	Support	
9:30 p.m.		Personal Time	Personal Time	Personal Time	Personal Time	Personal Time	
10:00 p.m.							
10:30 p.m.	Meditation						Meditation
11:00 p.m.	Lights Out	Lights Out	Lights Out	Lights Out	Lights Out	Liehts Out	Personal Time
11:30 p.m.							
12:00 р.т.	E				The Part of the same		Lights Out

Group Topics Included: belief restructuring, shame resiliency, relapse prevention, coping skills, interpersonal skills, inner child, forgiveness, resentment, physical wellness, mindfulness, connection, substance abuse, sexuality, self-awareness, & self-reliance, trauma resolution

Review of Treatment Outcomes

Author	Report	Date	Study Findings
DuPont, Compton, & McLellan	Five-Year Recovery: A New Standard For Assessing Effective Substance Use Disorder Treatment	20 15	 Using continuing management and monitoring to achieve goals of disease control and patient self-management enhances effectiveness Treatment that moves towards management of all substance use improves outcomes Innovation of evaluation contributes to an increase in successful long-term recovery
Grella, Joshi, & Hser	Program Variation in Treatment Outcomes Among Women in Residential Drug Treatment	2000	 Women only treatment centers offer more services to meet the specific needs of women including parenting, family, and vocational issues Women treated in women only centers are twice as likely to complete treatment Retention is increased in women only programs
Tracy, Laudet, Min, et. al	Prospective Patterns and Correlates in Quality of Life Among Women in Substance Abuse Treatment	2012	 Quality of life measures increased when treatment programs included services addressing trauma histories Increasing social supports and recovery services improve outcome effectiveness

DuPont, R. L., Compton, W. M., & McLellan, A. T. (2015). Five-Year Recovery: A New Standard for Assessing Effectiveness of Substance Use Disorder Treatment. *Journal of Substance Abuse Treatment (58) 1-5*.

Grella, C., Joshi, S., & Hser, Y. (2000). Program Variation in Treatment Outcomes Among Women in Residential Drug Treatment. *Evaluation Review, (24)4 364-383.*

Tracy, E. M., Laudet, A. B., Min, M. O., Kim, H., Brown, S., Jun, M. K., & Singer, L. (2012). Prospective Patterns and Correlates in Quality of Life Among Women in Substance Abuse Treatment. *Drug and Alcohol Dependence, (124) 242-249.*

Review of Optimal Group Size Studies

Author	Report	Date	Group size recommendation
Linhorst, D.	Summary of key findings of a process evaluation of the Ozark Correctional Center drug treatment program. U.S. Department of Justice http://www.ncjrs.gov/pdffiles1/nij/grants/181647.pdf	March 8, 2000	• optimal group size 12, maximum 16
John Howard Society	Perspectives on Canadian Drug Policy http://www.nald.ca/library/ research/drugs/perspect/ volume2/volume2.pdf	2004	 group size should be linked to program intensity, characteristics of participants, and experience of deliverers. groups size should be no less than 8 and no more than 12
Erickson, R.	Inpatient group psychotherapy: A survey. Clinical Psychology, 2, 137-151	1982	clinical custom is 8 members
Yalom, I	Theory and Practice of Group Psychotherapy (3rd ed.) New York: Basic Books	1985	8 is optimal number of group members
Scott, M. J., & Stradling, S. G	Group cognitive therapy for depression produces clinically significant change in community-based settings. <i>Behavioural Psychotherapy</i> , 18, 1-19.	1990	 group therapy was as effective as individual and treatment gains were still demonstrated at 6 months.
Slavson, S. R.,	Are there "group dynamics" in therapy groups? International Journal of Group Psychotherapy, 7, 131-154.	1957	 defines a group as having three or more members a minimal number of individuals is necessary in order to foster meaningful relationships. the size of psychotherapy groups often ranges between five to ten participants

Stewart, L., Usher, A., & Allenby, K. (2009). A Review of Optimal Group Size and Modularization or Continuous Entry Format for Program Delivery. *Research Branch Correctional Services of Canada*

Deborah M. Wayman, MS-MHC, CMHC (801) 971-2075

dwayman@renewtheself.com

Education:

Capella University – ABD/Ph.D., Counseling Studies (dissertation pending)
University of Phoenix – Master Degree, Mental Health Counseling, 1/2007 - 6/2010
Westminster College - Bachelor Degree, Psychology, 1/1999 - 6/2000
Salt Lake Community College - Associate Degree, Business Management, 6/1996

Mental Health Experience:

4/14-Present

Renew Counseling

Clinical Director

- · Provide individual, family, and group therapy in outpatient setting
- Manage daily practice business activities
- Provide clinical supervision
- Train and consult clinical team members

10/12-7/14

Pathways Real Life Recovery

Therapist

- · Provided individual and family therapy in intensive outpatient setting
- Provided assessment and evaluation of client needs and progress
- Facilitated insurance utilization and medical necessity reviews

12/11-09/12

Wasatch Recovery

Therapist

- Completed assessments and biopsychosocial reports
- Conducted psychoeducational and psychotherapy groups
- Provided individual, family, and group therapy
- Assisted with program development and group planning

11/11-Present

Iasis Healthcare

Behavioral Health: Crisis Team

- Conduct assessments and determine patient clinical needs
- Make treatment recommendations and facilitate referrals for service
- Facilitate inpatient placement as needed
- Coordinate services for detoxification and/or other substance use treatment needs
- Assist with training and supervision supports for crisis team members

11/11-3/14

Highland Ridge Hospital

Therapist

 Provided therapeutic services for adults and adolescents in inpatient acute psychiatric and chemical dependence programs Provided therapeutic services for partial hospitalization day treatment and intensive outpatient chemical dependence programs

3/10-7/15

Advantage Counseling

Therapist

- Provided individual, family, and group therapy in outpatient setting
- Developed group programming for adolescent groups
- Conducted educational groups for families and other support systems

5/09-12/11

Front Line Services

Therapist

- Provided individual, family, and group therapy for children, adolescents, and families in outpatient setting
- Conducted skill development groups for children and adolescents
- Provided homemaking consultation and assistance to families at risk

Business Experience:

(22 years: 1989 - 2011)

Management/Project Management - 8 years experience

- Assessed and evaluated staff performance
- Recommended and implemented continual quality improvement strategies
- Reviewed and analyzed effectiveness of quality control system procedures and documentation
- Developed programs and service offerings
- Designed and managed large communication system project implementations

Account Management/Sales/Customer Service - 14 years experience

- Established and maintained relationships with customers
- Developed written and visual presentations
- Presented problem resolution solutions to corporate executives and business owners

Other Experience:

Proficient in Microsoft Office applications: Word, Excel, Project, PowerPoint Trained in Intensive Attachment Theory
Certified in CPI Behavioral Intervention System
Certified in CPR/First Aid
Trained in Art and Play Therapy
Trained in Connections: Shame Resilience curriculum
Trained in EMDR Therapy

Associations & Licensure:

American Mental Health Counselors Association – Member since 2009,
Current, State Chapter Committee Member
Utah Mental Health Counselors Association – Board Member since 2010
Current, Conference Committee Chair
2014 Treasurer, 2013 Past President, 2012 President, 2011 President Elect
Licensed Clinical Mental Health Counselor # 4780650-6004